2022 Provider Manual

Illinois-Humana Gold Plus Integrated Medicare-Medicaid

Humana®

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Table of contents

Welcome

Thank you for your participation with Humana, where our goal is to provide quality services to Demonstration members. This provider manual is a contract extension designed to highlight key points related to Illinois Demonstration policies and procedures. Its goal is to be a guideline for facilitation that informs you and your staff:

- About the purpose that the Illinois Demonstration program is designed to serve
- What we need from you
- What you can expect from Humana and Carelon
- The guidelines outlined in this appendix are designed to help you provide caring, responsive service to our Humana Gold Plus®-integrated members

We look forward to a long and productive relationship with you and your staff. Should you need further assistance, please contact your network management consultant.

Sincerely,

Paul Maxwell
Vice President, Provider Development

Section I – General Provider Information

Program description

The Illinois-Humana Gold Plus Integrated Medicare-Medicaid Plan is a demonstration designed to improve healthcare for dually eligible Illinois beneficiaries. Jointly administered by the Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS), MMAI allows eligible Illinois beneficiaries to receive Medicare Part A, B and D benefits and Medicaid benefits from a single Medicare-Medicaid Plan, or MMAI, plan.

By integrating and coordinating individuals' health care benefits, the demonstration aims to:

- Improve quality and the beneficiary experience in accessing care;
- Promote person-centered care planning;
- Promote independence in the community;
- Rebalance long-term services and supports (LTSS) to strengthen and promote the community based systems; and
- Eliminate cost shifting between Medicare and Medicaid

The following information is intended as an orientation and guideline for the provision of covered services to health plan members and features policies, procedures and general reference information including minimum standards of care which are required of health plan providers.

Humana may choose not to distribute this information via surface mail, but rather give a written notification to you that explains how to obtain it from a website. This notification would also detail how you can request a hard copy at no charge. It is kept up-to-date and in compliance with state and federal laws. This information shall serve as a reference source regarding health plan's covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all requirements of a government-sponsored contract are met.

As part of its agency contract to provide Demonstration services, Humana will comply with MMAI contract provisions and applicable MMAI-related agency rules that the state may implement to regulate the plan administration.

NOTE: Manual Section I applies to all Demonstration providers. For additional details related to long-term service and support providers, please see Section II of the manual. For additional details related to behavioral health providers, please see Section III.

Covered services

General services

Through its contracted providers, the Demonstration health plan is required to arrange for medically necessary services for each member. When providing covered services to plan members, the provider must adhere to applicable plan coverage provisions and all applicable state and federal laws.

Out-of-network care for unavailable services

Upon notification of authorization from a referring provider, Humana will arrange out-of-network care if unable to provide necessary covered services or ensure the second opinion of a participating network provider.

Expanded services

Expanded services are those offered by Humana and approved in writing by the state. Such services are outlined in the benefit summaries below. For additional information, providers can call the customer service number provided on the back of the Humana member's ID card.

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

TABLE 1-1 COVERED PLAN SERVICES (GENERAL)

$0 MEMBER COPAY

Abdominal aortic aneurysm screening

The plan will cover a one-time ultrasound screening for at-risk members. The plan covers this screening only if the member has certain risk factors and receives a referral from his or her physician, physician assistant, nurse practitioner or clinical nurse specialist.

Acupuncture for chronic low back pain

The plan will pay for up to 12 visits in 90 days for members who have chronic low back pain, defined as:

- Lasting 12 weeks or longer; not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease)
- Not associated with surgery
- Not associated with pregnancy

The plan will pay for an additional eight sessions if the member show improvement. The member may not get more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if there is no improvement.

Alcohol misuse screening and counseling

The plan covers one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.

If a member screens positive for alcohol misuse, the plan covers up to four brief, face-to-face counseling sessions each year (if member is able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.

Ambulance services

Covered ambulance services include fixed-wing, rotary and ground ambulance services.

The ambulance will take the member to the closest facility that can provide care. The member's condition must be serious enough to mean that travel to an alternative location could risk the member's life or health. Ambulance services for other cases must be approved by the plan.

In cases that are not emergencies, the plan may pay for an ambulance if the condition is serious enough to mean that travel to an alternate location could risk the member's life or health.

Annual wellness visit

Members who have received Medicare Part B coverage for more than 12 months can get an annual checkup to create or update a prevention plan based upon current risk factors. The plan will cover this checkup once every 12 months.

NOTE: Initial annual member checkups conducted within 12 months of a "Welcome to Medicare" preventive visit are not covered. The "Welcome to Medicare" visit is not a pre-requisite for annual checkup coverage.

Behavioral health crisis services

The health plan is expanding services to include mobile crisis response (MCR) and crisis stabilization services. Expanded crisis services may be provided for up to 30 days following an MCR event to prevent additional behavioral health crises.

To access MCR services, health plan members or concerned individuals should call CARES, the state's crisis intake line, at **800-345-9049 (TTY: 866-794-0374)**. CARES will dispatch a local provider to the location of the health plan member in crisis. The health plan will cover mobile crisis response and crisis stabilization services provided by:

- Community mental health centers (CMHC) with state crisis certification
- Behavioral health clinics with state crisis certification

Bone mass measurement

The plan covers certain qualifying member procedures (that include risk of osteoporosis or loss of bone mass). These procedures identify bone mass or assess bone quality. The plan will cover the services once every 24 months, or more often if medically necessary. The plan also will pay for a doctor to review and comment on the results.

COVERED PLAN SERVICES (GENERAL) – continued

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Breast cancer screening (mammograms)

The plan will cover the following services:

- One baseline mammogram between the ages of 35 and 39
- One screening mammogram every 12 months for women 40 and older
- Clinical breast exams once every 24 months

Cardiovascular disease risk reduction visit (heart disease therapy)

The plan covers one PCP visit per year to help lower heart disease risks. During this visit,

the PCP may:

- Discuss aspirin use
- Check member blood pressure
- Provide tips for healthy eating

Cardiovascular disease testing

The plan covers blood tests to check for cardiovascular disease once every five years (60 months). These tests also check for heart defects due to high heart disease risk. Additional testing may be provided by the member's primary care provider, if medically necessary.

Cellphone services

If members qualify for the federal free cellphone program, Lifeline Program for Low-income Consumers, we offer a pre-loaded toll-free phone number that allows members to call our customer care team. Members also receive free health-related texts and messages.

Cervical and vaginal cancer screening

The plan covers Pap tests and pelvic exams once every 12 months

Chiropractic services

The plan covers adjustments of the spine to correct alignment.

Dental services

The plan covers the following dental services:

- Limited and comprehensive exams
- Restorations
- Dentures
- Extractions
- Sedation
- Dental emergencies
- Dental services necessary for the health of a pregnant woman prior to delivery of her baby

The following additional dental benefits are covered:

- One oral exam every six months
- One prophylaxis-cleaning every six months

Depression screening

The plan will cover one depression screening each year.

The screening must be conducted in a primary care setting that can give follow-up treatment and referrals.

Diabetes screening

The plan will cover this screening (includes fasting glucose tests) if the member has any of the following risk factors:

- High blood pressure (hypertension)
- History of abnormal cholesterol and triglyceride levels(dyslipidemia)
- Obesity
- History of high blood sugar (glucose)

Tests may be covered in some other cases, such as if the member is overweight and has a family history of diabetes. Depending on the test results, the member may qualify for up to two diabetes screenings every 12 months.

COVERED PLAN SERVICES (GENERAL) – continued

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Emergency care

Emergency care is:

- Administered by a provider trained to give emergency services
- Required to treat a medical emergency

A medical emergency is defined as a medical condition involving serious pain or injury that, without immediate medical attention, those with an average knowledge of health and medicine could expect it to result in:

- Placing the member's health in serious risk
- Serious harm to bodily functions
- Serious dysfunction of any bodily organ or part

In the case of a pregnant woman, an active labor when either of the following would occur:

- There is not enough time to safely transfer the member to another hospital before delivery.
- The transfer may pose a threat to the health or safety of the member or unborn child.

Emergency care coverage is provided world-wide.

NOTE: If a member receives emergency care at an out-of-network hospital and requires inpatient care after the condition has stabilized, he or she must return to a network hospital in order for continued care to be paid by the plan. Only plan approval permits a member to remain in the out-of-network hospital for inpatient care.

Gender-affirming services

For members with a diagnosis of gender dysphoria, the plan covers gender-affirming services. Some screenings and services are subject to prior authorization and referral requirements.

Health and wellness education programs

The plan provides the following services:

- Online and printed health education materials and tools
- Disease management programs
- Nutrition counseling

HIV screening

The plan pays for one HIV screening exam every 12 months for members who:

- Request an HIV screening test
- Are at increased risk for HIV infection

For pregnant women, the plan pays for up to three HIV screening tests during a pregnancy

Hospice care

Members can receive care from any Medicare-certified hospice program and have the right to elect hospice if a terminal prognosis is assessed by a member's provider and the hospice medical director.

NOTE: Medicare-certified hospice and Medicare Part A and B services related to terminal illness are covered by Medicare. Humana Gold Plus Integrated (Medicare-Medicaid Plan) does not pay for those member services.

A terminal illness is defined as the determination that a member has six months or less to live. The hospice doctor can be a network provider or an out-of-network provider.

The plan will cover the following while members receive hospice services:

- Drugs to treat symptoms and pain
- Short-term respite care
- Home care, including home health aide services
- Occupational, physical and speech-language therapy services to control symptoms
- Counseling services

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COVERED PLAN SERVICES (GENERAL) – continued

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Hospice care – continued

Hospice services and services covered by Medicare Part A or B are billed to Medicare

Humana Gold Plus Integrated (Medicare-Medicaid Plan) will pay for plan-covered services not covered under Medicare Part A or B. The plan will cover the free services even when they are not related to the member's terminal prognosis.

For drugs that may be covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan) Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan

NOTE: Members needing non-hospice care should contact a Customer Care coordinator at **800-787-3311 (TTY: 711)** to arrange for assistance. We're available Monday – Friday, 8 a.m. – 8 p.m. local time. Our automated phone system may answer after-hours calls, during weekends and holidays. A member must provide his or her name and telephone number, and we'll respond by the end of the next business day. Visit Humana.com for 24-hour access to information such as claims history, eligibility and Humana's drug list. Members can obtain health news and information and use the Physician Finder.

Immunizations

The plan covers the following services:

- Pneumonia vaccine
- Flu shots, once a year, (during fall or winter months)
- Hepatitis B vaccine (if members are at immediate/high or risk of contracting the disease)
- Other vaccines (if member is at risk and meets Medicare Part B coverage rules)

The plan will cover other vaccines that meet the Medicare Part D coverage rules.

Medical nutrition therapy

This benefit is for members with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by their doctor.

The plan will cover three hours of one-on-one counseling services during the member's first year that they get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that.

If the member's condition, treatment, or diagnosis changes, they may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year.

Medicare diabetes prevention program (MDPP)

The plan will pay for MDPP services. MDPP is designed to help member's increase healthy behavior. It provides practical training in:

- Long-term dietary change
- Increased physical activity
- Ways to maintain weight loss and a healthy lifestyle

Non-Medicaid over-the-counter drugs

Members are eligible for as much a $30 quarterly allowance for the purchase of over-the-counter health and wellness products available through CenterWell®, our mail order pharmacy.

Nurse Advice Call Line (HumanaFirst®)

Members who have symptom questions and concerns can call HumanaFirst – our member advice line — toll free, 24 hours a day, seven days a week at **855-235-8530 (TTY: 711)**. The call center is staffed by nurses who can help address immediate member health concerns and answer questions about particular medical conditions.

Obesity screening and weight management therapy

Members with a body mass index (BMI) of 30 or greater may receive plan-covered counseling to help with weight loss. Counseling must be received and managed in a primary care setting as part of the member's full prevention plan.

COVERED PLAN SERVICES (GENERAL) – continued

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Opioid treatment program

The plan will cover the following services to treat opioid use disorder:

- Medications approved by the Food and Drug Administration (FDA) and, if applicable, management and administration of medications
- Substance use counseling
- Individual and group therapy
- Member toxicology testing

Physical exam (routine)

In addition to the "Annual Wellness Exam" preventive visit, the plan covers a comprehensive preventive medicine evaluation and management examination once per year. Specific exam elements include age, gender, appropriate history, an examination and counseling, anticipatory guidance and risk factor reduction interventions.

Post-discharge meal program

After an inpatient hospital or nursing facility stay, members may receive two free meals per day for five days (a total of 10 nutritious, pre-cooked frozen meals will be delivered to the member's home). Meal program access is limited to four times per calendar year.

Please contact Well Dine toll free at **866-96MEALS (866-966-3257) TTY: 711** for further details or to take advantage of this discharge benefit.

Prostate cancer screening exams

The plan will cover a digital rectal exam and a prostate-specific antigen (PSA) test once every 12 months for:

- Men 50 and older
- African-American men 40 and older
- Men 40 and older with a family history of prostate cancer

Transplant services

- The Humana transplant services team helps members and their physicians navigate the complex world of transplant care and make informed decisions. Explaining the benefit structure and helping members maximize their benefits
- Helping members choose a transplant program
- Dedicating transplant care managers for authorization and care management services
- Dedicating specially trained staff to handle claims quickly and efficiently

To reach Humana's team of transplant care managers, call **866-421-5663**, email transplant@humana.com or reach out by fax at fax number **502-508-9300**. Care managers are available to assist you Monday through Friday, 8 a.m. to 5 p.m. local time. Messages left after hours will receive a response the next business day.

Sexually transmitted infections (STIs) screening and counseling

The plan will cover the following screenings for pregnant women and plan members at increased STI risk once every 12 months (or at certain times during pregnancy):

- Chlamydia
- Gonorrhea
- Syphilis
- Hepatitis B

The plan also will cover up to two 30-minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. The plan will cover these counseling sessions as a preventive service only if provided by a PCP. The sessions must be in a primary care setting, such as a doctor's office.

COVERED PLAN SERVICES (GENERAL) – continued

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Substance abuse services

The plan will cover substance abuse services provided by:

- A state-licensed substance abuse facility
- Hospitals

The plan will cover the following types of medically necessary substance abuse services:

- Group or individual outpatient services such as assessment, therapy, medication monitoring and psychiatric evaluation
- Medication-assisted treatment (MAT) for opioid dependency (such as ordering and administering methadone), managing the care plan, and coordinating other substance use disorder services
- Intensive outpatient services (group or individual)
- Detoxification services
- Some residential services, such as short-term rehabilitation services

Supervised exercise therapy (SET)

The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who've been referred by the treating peripheral artery disease (PAD) physician.

The SET program must:

- Consist of 30- to 60-minute sessions of a therapeutic exercise-training program for PAD for members with leg cramping due to claudication
- Take place in a hospital outpatient physician's office setting
- Be delivered by qualified personnel who ensure that benefit exceeds harm and are trained in exercise therapy for PAD

Be conducted under the direct supervision of a physician, physician assistant or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques

Urgently needed care

Urgently needed care is care given to treat:

- A non-emergency
- A sudden medical illness
- An injury
- A condition that needs care right away.

If a member requires urgently needed care, they should first try to get it from a network provider. However, members can use out-of-network providers when you cannot get to a network provider. Members are covered for urgently needed care in the US and its territories.

Vision care

The plan covers the following:

- Annual routine eye exams
  - Eye glasses (lenses and frames)
  - Frames limited to one pair in a 24 month period
- Lenses limited to one pair in a 24 month period, but you may get more when medically necessary, with prior approval
- Custom-made artificial eye
- Contacts and special lenses when medically necessary, with prior approval

The plan covers outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.

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COVERED PLAN SERVICES (GENERAL) – continued

$0 MEMBER COPAY

Vision care – continued

For people at high risk of glaucoma, the plan covers one glaucoma screening each year. People at high risk of glaucoma include:

- people with a family history of glaucoma,
- people with diabetes,
- African-Americans who are age 50 and older, and
- Hispanic Americans who are 65 or older.

The plan covers one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If the member has two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.)

"Welcome to Medicare" preventive visit

The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes:

- Member health review
- Necessary member preventive service education and counseling, including screenings and shots
- Necessary member referrals for other care

NOTE: We cover the "Welcome to Medicare" preventive visit only during the first 12 months of a member's Medicare Part B coverage. Members should be encouraged to schedule the preventive visit when scheduling a doctor's office appointment.

$0 MEMBER COPAY (Prior authorization may be required)

COVID care package

This health plan includes a COVID care package. Covered services include:

- One respiratory care kit per year. Kit includes over the counter items useful for preventing the spread of COVID-19
- Lab testing

For members with a confirmed COVID-19 diagnosis, this benefit will also include:

- Hospitalization, medical services, and prescription drugs
- Home delivered meals – 14 days (28 meals)

Family planning services (Prior authorization is required for infertility and genetic testing)

Members may receive family planning services from the provider (doctor, clinic, hospital, pharmacy or family planning office) of his or her choice.

The plan will cover the following services:

- Family planning exam and medical treatment
- Family planning lab and diagnostic tests
- Family planning methods (birth control pills, patch, ring, IUD, injections, implants)
- Prescribed family planning supplies (condom, sponge, foam, film, diaphragm, cap)
- Infertility diagnosis, counseling and related services
- Counseling and testing for sexually transmitted infections (STIs), AIDS and other HIV-related conditions
- Treatment for sexually transmitted infections (STIs)
- Voluntary sterilization
  - Members must be 21 or older and sign a federal sterilization consent form.
  - At least 30 days (but not more than 180 days) must pass between the date a member signs the form and the date of surgery.

Genetic counseling

- Prescribed and pharmacy-dispensed folic acid supplements and prenatal vitamins
- Certain family planning services. Members must see a network provider for the following services:
  - Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)
  - Treatment for AIDS and other HIV-related conditions
  - Genetic testing

COVERED PLAN SERVICES (GENERAL) – continued

$0 MEMBER COPAY (Prior authorization may be required)

Hearing services

The plan covers hearing and balance tests done by the member's provider to assess medical treatment needs. The tests are covered as outpatient care when conducted by a physician, audiologist or other qualified provider. The plan also covers the following:

- Basic and advanced hearing tests
- Hearing aid counseling
- Hearing aid evaluation and fitting
- One hearing aid per ear every three years
- Hearing aid batteries and accessories
- Hearing aid repair and replacement parts

Home health agency care

Before receiving home health services, a doctor must confirm member need, and those services must be provided by a home health agency. The plan will cover various services, including:

- Part-time or intermittent skilled nursing and home health aide services. (When covered under the home healthcare benefit, skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week)
- Physical therapy, occupational therapy and speech therapy
- Medical and social services
- Medical equipment and supplies

Inpatient hospital care (referral also may be required)

NOTE: Members must receive plan approval to keep receiving inpatient care at an out-of-network hospital after an emergency condition is stabilized. The plan will cover the various services, including the following:

- Semi-private room (or a private room if medically necessary)
- Drugs and medications
- Necessary surgical and medical supplies
- Inpatient substance abuse services
- Special care units (such as intensive or coronary care units)
- Appliances, such as wheelchairs
- Physical, occupational and speech therapy
- Regular nursing services
- X-rays and other radiology services
- Physician services
- Meals (including special diets)
- Lab tests
- Operating and recovery room services
- Blood storage, blood components and administration

In some cases, the following types of transplants:

- Cornea
- Kidney
- Kidney/pancreatic
- Heart
- Stem cell
- Liver
- Lung
- Heart/lung
- Bone marrow
- Intestinal/multi-visceral

If the member needs a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Humana Gold Plus Integrated H0336-000 (Medicare-Medicaid Plan) provides transplant services at a location outside the pattern of care for transplants in the member's community and they choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. If the member is in need of a solid organ or bone marrow/stem cell transplant, please contact our Transplant Department at **866-421-5663** for important information about their transplant care.

Inpatient mental healthcare

The plan will cover medically necessary psychiatric inpatient care at approved institutions.

COVERED PLAN SERVICES (GENERAL) – continued

$0 MEMBER COPAY (Prior authorization may be required)

Inpatient services covered during a non-covered stay

The plan will not cover unnecessary inpatient member stays. However, in some cases the plan will cover member services received during a hospital or nursing facility stay.

The plan will cover the following (and may cover other) services:

- Doctor services
- Diagnostic tests, such as lab tests
- X-ray, radium and isotope therapy, including technician materials and services
- Surgical dressings
- Splints, casts and other devices used for fractures and dislocations
- Prosthetics and orthotic devices (other than dental), including device replacement or repair.
  These devices:
  - Replace all or part of an internal body organ (including contiguous tissue)
  - Replace all or part of the function of an inoperative or malfunctioning internal body organ.
- Leg, arm, back and neck braces, trusses, and artificial legs, arms and eyes. This includes adjustments, repairs and replacements needed because of breakage, wear, loss or a change in the patient's condition
- Physical, speech and occupational therapy

Kidney disease services and supplies

The plan will cover the following services:

- Kidney disease education services to teach organ care and help members make good care decisions. Members must have stage IV chronic kidney disease and be doctor-referred. The plan will cover up to six sessions of kidney disease education services.
- Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area
- Inpatient dialysis treatments, if admitted for inpatient hospital special care
- Self-dialysis training for members and caregivers that help with home dialysis treatments
- Home dialysis equipment and supplies
- Certain home support services, such as necessary trained dialysis workers visits to check home dialysis equipment, help during emergencies and to check water supply

The member's Medicare Part B drug benefit pays for some dialysis drugs. For information, please see "Medicare Part B prescription drugs" in this chart.

Medical equipment and related supplies

The following general types of services and items are covered:

- Non-durable medical supplies, such as surgical dressings, bandages, disposable syringes, incontinence supplies, ostomy supplies and enteral nutrition therapy
- Durable medical equipment, such as wheelchairs, crutches, walkers, hospital beds, IV infusion pumps and supplies and humidifiers.
- Prosthetic and orthotic devices, compression stockings, shoe orthotics, arch supports and foot inserts
- Respiratory equipment and supplies, such as oxygen equipment, CPAP and BIPAP equipment
- Repair of durable medical equipment, prosthetic and orthotic devices
- Rental of medical equipment under circumstances where patient's needs are temporary

To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria. We will pay for all medically necessary durable medical equipment usually covered by Medicare and Medicaid. If our supplier in the member's area does not carry a particular brand or maker, he or she may request that items be special ordered.

COVERED PLAN SERVICES (GENERAL) – continued

$0 MEMBER COPAY (Prior authorization may be required)

Medicare Part B prescription drugs are defined as those medications covered under Part B of Medicare. Humana Gold Plus Integrated (Medicare-Medicaid Plan) will cover the following drugs:

- Drugs that are injected or infused while members receive doctor, hospital outpatient or ambulatory surgery center services
- Drugs that use plan-authorized durable medical equipment (such as nebulizers)
- Self-administered clotting factor injections for members with hemophilia
- Immunosuppressive drugs for Medicare Part A-enrolled members at the time of organ transplant
- Injected osteoporosis drugs are covered for homebound members with a bone fracture that a doctor certifies is related to post-menopausal osteoporosis and cannot be self-injected
- Antigens
- Certain oral anti-cancer and anti-nausea drugs
- Certain home dialysis drugs, including heparin, the antidote for heparin (when medically necessary), topical anesthetics and erythropoiesis-stimulating agents (such as Epogen® or Procrit®)
- IV-immune globulin for home treatment of primary immune deficiency diseases
- Chemotherapy drugs and administration

Non-emergency transportation

The plan will cover member transportation to or from medical appointments if the service is covered. Types of non-emergency transportation include:

- Non-emergency ambulance
- Shared service car
- Taxicab

Unlimited round trip(s) per year by taxi, bus or subway, passenger van, medical transport are covered when traveling to nursing homes, pharmacy (immediately following doctor visits) and other medical providers and locations.

Prior authorization and/or referral may be required.

Nursing-facility care and skilled-nursing facility care

The plan will cover skilled nursing facilities (SNF) and intermediate care facilities (ICF). The

nursing facilities provide the following, and possibly other, services:

- A semi-private or private room (if medically necessary), maintenance and cleaning
- Meals, including special meals, food substitutes and nutritional supplements
- Nursing services and resident supervision/oversight
- Physician services
- Physical, occupational and speech therapy
- Physician-ordered medications available through a pharmacy without a prescription as part of the member's plan of care (including self-administered over-the-counter medications)
- Non-custom durable medical equipment (such as wheelchairs and walkers)
- Medical and surgical supply items, such as bandages, oxygen administration supplies, oral care supplies and equipment, and one tank of oxygen per resident per month
- Additional services provided by a nursing facility in compliance with state and federal requirements

Members may receive out-of-network facility care if the facility accepts our plan's out-of-pocket payment amounts:

- A nursing home or continuing care retirement community where the member lived before his or her hospital stay, as long as it provides nursing facility care
- A nursing facility where the member's spouse lives upon the member's hospital release.

Prior authorization and/or referral may be required.

NOTE: When member income exceeds an allowable amount, the member must contribute toward the cost of services. This is known as the patient pay amount and is required if a member lives in a nursing facility.

Patient pay responsibility does not apply to Medicare-covered days in a nursing facility.

COVERED PLAN SERVICES (GENERAL) – continued

$0 MEMBER COPAY (Prior authorization may be required)

Outpatient diagnostic tests and therapeutic services

The plan will cover the following (and possibly other) services:

- X-rays
- Radiation (radium and isotope) therapy, including technician materials and supplies
- Lab tests
- Blood, blood components and their administration
- Other outpatient diagnostic tests:
  - Surgical supplies, such as dressings
  - Splints, casts, and other devices used to reduce fractures and dislocations
  - Home or facility-based sleep studies
  - Diagnostic mammography

Prior authorization and/or referral may be required.

Outpatient hospital services

The plan pays for medically needed services members receive through a hospital outpatient department for diagnosis or treatment of an illness or injury.

The plan will cover the following (and perhaps other unlisted) services:

- Emergency department or outpatient clinic services (i.e. observation services or outpatient surgery)
- Labs and diagnostic tests billed by the hospital
- Mental healthcare (including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would otherwise be needed)
- X-rays and other radiology services billed by the hospital
- Medical supplies, such as splints and casts
- Some screenings and preventive services
- Some drugs that cannot be self-administered
  - Nuclear medicine services
  - Radiation therapy

Prior authorization and/or referral may be required.

Outpatient mental healthcare

The plan will cover mental health services provided by:

- A state-licensed psychiatrist or doctor
- A clinical social worker
- A nurse practitioner
- Community mental health centers (CMHCs)
- A clinical psychologist
- A clinical nurse specialist
- A physician assistant
- Hospitals
- Division of Alcoholism and Substance Abuse (DASA)-licensed substance abuse providers or any other Medicare-qualified mental healthcare professionals as allowed under applicable state laws
- Encounter rate clinics, e.g., federally qualified health centers (FQHCs)

The plan will cover the following types of outpatient mental health services:

- Clinic services provided under the direction of a physician
- Rehabilitation services recommended by a physician or licensed practitioner of the healing arts (i.e. mental health assessment, treatment planning, crisis intervention, therapy and case management)
- Day treatment services
- Outpatient hospital services, such as Type A and B clinic service options
- Substance abuse treatment

The utilization controls on the specific provider services listed above shall be determined by the plan in accordance with federal and state laws and all applicable policies and/or agreements.

COVERED PLAN SERVICES (GENERAL) – continued

$0 MEMBER COPAY (Prior authorization may be required)

Expanded outpatient mental health crisis services

The crisis service array is expanded to include mobile crisis response (MCR) and crisis stabilization services. MCR services require face-to-face screening using the state-approved crisis screening instrument. Consistent with state regulations, transition to additional crisis or other rehabilitation services may occur after the MCR event is completed to ameliorate the crisis situation.

The state's centralized crisis intake line, CARES, accepts MCR service referrals for members experiencing a behavioral health crisis. Crisis stabilization services may be provided for up to 30 days following an MCR event and require a demonstrated need for ongoing stabilization support as documented on a local public health agency (LPHA)-approved crisis safety plan.

Prior authorization and/or referral may be required.

Outpatient rehabilitation services

The plan will cover physical therapy, occupational therapy and speech therapy.

Rehabilitation services are available from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs) and other facilities. Prior authorization and/or referral may be required.

Outpatient surgery

The plan will cover outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. Prior authorization and/or referral may be required.

Partial hospitalization services

Partial hospitalization is defined as a structured program of active psychiatric treatment offered in an outpatient hospital setting or by a community mental health center. To prevent inpatient hospital stays, it is more intense than care offered in the member's doctor or therapist office.

Prior authorization and/or referral may be required.

Physician/provider services including doctor's office visits

The plan will cover the following services:

- Medically necessary healthcare or surgery services given in places such as:
  - Physician's office
  - Certified ambulatory surgical center
  - Hospital outpatient department
- Specialist consultation, diagnosis and treatment
- Doctor-ordered PCP hearing and balance testing to assess treatment needs
- Some telehealth services, including physician and practitioner consultation, diagnosis for patients living in rural areas or other Medicare-approved locations
- Telehealth services to diagnose, evaluate or treat symptoms of a stroke
- Virtual five- to 10-minute provider check-ins (for example, by phone or video chat) are viable if:
  - The member is a new patient
  - The check-in is unrelated to an office visit made within the past seven days
  - The check-in doesn't lead to an office visit within 24 hours or earliest-available appointment
- Second opinion before a medical procedure from a network provider
- Non-routine dental care covered services are limited to:
  - Surgery of the jaw or related structures
  - Setting fractures of the jaw or facial bones
  - Pulling teeth before radiation treatments of neoplastic cancer
  - Services that would be covered when provided by a physician

Prior authorization and/or referral may be required.

COVERED PLAN SERVICES (GENERAL) – continued

$0 MEMBER COPAY (Prior authorization may be required)

Podiatry services

The plan will cover the following services:

- Diagnosis and medical or surgical treatment of foot injuries and diseases (such as hammer toe or heel spurs)
- Routine foot care for members with conditions affecting the legs, such as diabetes

Members are covered for additional podiatry benefits and may self-refer to a network specialist for up to six visits each year for the following services:

- Treatment of flat feet or other structural misalignments of the feet
- Wart removal
- Hygienic care
- Corn removal
- Callus removal

Prior authorization and/or referral may be required.

Prosthetic devices and related supplies

Prosthetic devices replace all or part of a body part or function. The plan covers these (and other) prosthetic devices:

- Colostomy bags and supplies related to colostomy care
- Braces
- Breast prostheses (including a surgical brassiere after a mastectomy)
- Pacemakers
- Prosthetic shoes
- Artificial arms and legs

The plan also will cover some supplies related to prosthetic devices and for prosthetic device replacement or repair. It also offers some coverage after cataract removal or cataract surgery.

Prior authorization and/or referral may be required.

Cardiac rehabilitation services

The plan covers cardiac rehabilitation services such as exercise, education and counseling. Members must meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs.

$0 MEMBER COPAY (Referral may be required)

Counseling to stop smoking or tobacco use

For tobacco-using members showing no signs or symptoms of tobacco-related disease, the plan will cover:

- Two quit counseling attempts in a 12-month period as a free preventive service

For tobacco-using members diagnosed with a tobacco-related disease or taking medicine that may be affected by tobacco, the plan will cover:

- Two counseling quit attempts within a 12-month period

For pregnant tobacco-using members, the plan will cover:

- Three free quit counseling attempts within a 12-month period

NOTE: Each counseling attempt includes up to four face-to-face visits

Lung cancer screening

The plan will pay for lung cancer screening every 12 months if a member:

- Is aged 55-77
- Member has counseling and shared decision-making with doctor or other qualified provider
- Has smoked at least one pack a day for 30 years with no signs or symptoms of lung cancer
- Current smoker
- Has quit within the last 15 years

Pulmonary rehabilitation services

The plan will cover pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD).

The member must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD.

Referral may be required.

Excluded benefits – Humana Gold Plus Integrated, Medicare–Medicaid Plan

The following benefits are excluded from plan coverage. Excluded benefits are defined as services covered by neither this plan nor Medicaid nor Medicare. Some services and items are not covered by the plan at all, while others are excluded only in some cases.

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

Members who believe that an excluded service should be covered may file an appeal. For information about filing an appeal, see page 27.

Utilization management

Our Utilization Management (UM) Program is designed to ensure members receive access to the right care in the right place 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

Preauthorization is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from the plan as to whether an item, drug or service will be covered.

Notification refers to the process of the physician or other healthcare provider notifying Humana of the intent to provide an item, drug or service. Humana may request notification, as this helps coordinate care for your Humana-covered patients. This process is distinguished from preauthorization, as it does not result in an approval or denial.

Our preauthorization list is at Humana.com/PAL. You also can call Customer Service (**800-HUMANA**) to request a hard copy of the list. Please note that the preauthorization list is subject to change.

Requests for preauthorization should be made as soon as possible but at least 14 days in advance of the service date. Note: Emergent/urgent care does not require preauthorization. However, providers should notify Humana within 48 hours for initiation of these services.

If preauthorization is required and not obtained, it may result in reduction or denial of payment. Services provided without preauthorization also may be subject to retrospective review. When retrospective review is performed, providers should include clinical information to perform a medical necessity review, as well as a summary of why preauthorization was not obtained.

How to request a preauthorization

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

- Visit Availity.com (registration required). For many services that require preauthorization, you can answer a series of questions when requesting the preauthorization. If approved, you will receive notification immediately. If pended for further review, you can attach relevant clinical information to the request to expedite the process.
- Submit a B2B or batch Health Care Services Review and

Response transaction (278) via EDI.
- Use our interactive voice response system (IVR) by calling **800-523-0023**.
- Call the number for precertification on the back of the patient's Humana ID card
- Fax the request to **855-227-0677**.

If a request needs to be expedited due the seriousness of a patient's condition, call **800-523-0023**.

Required information

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

- Member's ID number and date of birth
- Relationship to subscriber
- Date of actual service or hospital admission
- Type of service
- Place of service
- Service quantity
- Procedure codes, up to a maximum of 10 per authorization request
- Date of proposed procedure, if applicable
- ICD Diagnosis codes (primary and secondary), up to a maximum of six per authorization request
- Service location
  - Inpatient
- Acute hospital
- Skilled nursing
- Hospice
  - Outpatient
- Telehealth
- Office
- Home
- Off-campus outpatient hospital
- On-campus outpatient hospital
- Ambulatory surgery center
  - Referral
- Type of authorization – inpatient or outpatient
- Tax ID number and National Provider Identifier (NPI) number of requesting provider
- Tax ID number and NPI of treatment facility where service is being rendered
- Tax ID number and NPI of the provider performing the service
- Name and telephone number of all providers indicated
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans
- Other

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

Referrals

If a patient requires specialized treatment beyond the scope of a primary care physician (PCP), he/she can be referred to a specialist for consultation and/or treatment. Humana contracts with specialists in the plan's service area. See the providers' section of Humana.com for Humana's claims payment policy on ordering provider and referring provider requirements. Referrals are not required to see some specialists, such as women health specialists.

The PCP initiates the referral by submitting a referral request through Availity.com. Methods for submitting referral requests are outlined in the Preauthorization section above and on Humana's website. The 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 also must be obtained by the specialist for any additional medications or services on the preauthorization and notification list.

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

Referrals are not required for members with PPO plans. Preauthorization for medications and services on the preauthorization and notification list is required. The list is at Humana.com/PAL, or a copy can be requested from Humana Customer Service (**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 MMAI 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 also must contact Humana with the discharge date and discharge disposition upon patient discharge.

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 no longer are valid, the facility should follow the instructions under the "Special requirements for hospitals" section.

Discharge planning

The Humana UM team collaborates with the Humana-covered patient and his/her family or guardian, the hospital's UM and discharge planning departments and the patient's attending physician/PCP to facilitate the 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 MMAI plans, Humana applies Medicare national coverage determinations (NCDs) and local coverage determinations (LCDs) as well as IL Medicaid coverage guidelines. Humana also develops internal clinical policies, Humana medical coverage policies (HMCPs), based on peer-reviewed literature. Humana's Medical Coverage Policies are available here.

A licensed, board-certified medical director reviews all available clinical documentation to evaluate if guidelines are met. 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.

For MMAI 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 have five calendar days from notification of the denied authorization to request the pre-claim dispute. As part of this pre-claim dispute, providers can request a peer-to-peer conversation if one did not occur prior to the adverse determination. Participating providers also can submit claim disputes via the outlined claims dispute process section of this manual.

Second medical opinion

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

Follow-up services must be obtained through or arranged by the member's PCP.

Special requirements for hospitals

Hospital discharge rights for MMAI members: CMS requires that hospitals deliver the Important message from Medicare (IM), CMS-10065, to all Medicare beneficiaries, including MMAI plan members who are hospital inpatients. Hospitals are required to provide the IM to the MMAI 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 are on the CMS website at cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

The IM informs hospitalized MMAI beneficiaries about their hospital discharge appeal rights. MMAI 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/her representative, then the hospital staff should telephone the representative to advise him/her of a 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/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 representative contacted by phone, the date and time of telephone contact and the telephone number called.

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

- Send the notice to the 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 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 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/she can request an expedited reconsideration (appeal) through Humana's appeals department. For more information about notification of termination requirements, practitioners can visit the CMS website at cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

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 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 MMAI 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 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 MMAI 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 cms.gov/Medicare/Medicare-General-Information/BNI.

Additional information about the MOON can be found on the CMS Medicare Learning Network site at cms.gov/newsroom/fact-sheets/medicare-outpatient-observation-notice-moon

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/)MMAI) 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 QIO if they disagree with the termination.

The form and instructions regarding the NOMNC are available on the CMS website at cms.gov/Medicare/Medicare-General-Information/BNI

Practitioners also can contact their QIO for forms or additional information. Forms also can 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/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/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, mailed to the representative the same day as the telephone contact, and 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 MMAI members, when coverage of their SNF, HHA or CORF services will soon 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 delegated to the practitioner for completion) 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 can visit the CMS website at: cms.gov/Medicare/Medicare-General-Information/BNI.

Emergency service responsibilities

Participating providers are required to ensure adequate accessibility for healthcare 24 hours-per-day, seven days-per-week. An after-hours telephone number must be available to members. Voice mail is not permitted. Members should go to the closest emergency room or any other emergency setting if experiencing symptoms such as any of the following:

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

If the member is treated and stabilized during an emergency visit, and the treating doctor recommends continued treatment, the member is instructed to call his or her Humana PCP. Members who suffer an emergency while away from home are instructed to go to the nearest emergency room or setting. In such situations, the member's PCP should be contacted soon as possible.

Emergency mental health services

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

For emergency behavioral healthcare, please instruct members to go to the nearest hospital emergency room or any other recommended emergency setting. They should contact their provider first if they are unsure whether the problem is an emergency. Emergency behavioral health conditions include:

- Becoming a danger to themselves or others
- Being unable to carry out actions of daily life due to so much functional harm
- Threat of serious harm to the body that may cause death

Model of care and care coordination

Overview of the CMS-approved model of care

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

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

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

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

Continuity of care

Humana offers an initial 180-day transition period for new Demonstration members to maintain a current course of treatment with an out-of-network provider. Humana offers a 90-day transition period for members transitioning to Humana from another Demonstration plan. The 180-day and 90-day transition periods are applicable to all providers, including behavioral health providers and LTSS providers. Non-participating PCPs and specialists providing an ongoing course of treatment will be offered single-case agreements to continue member care beyond the transition period if they remain outside the network or until a qualified, affiliated provider is available.

Provider's role and responsibilities in care coordination, care transitions, comprehensive medication reviews and preventive screenings include:

- Deliver evidence-based medical management addressing member needs, choices and cultural preferences
- Ensure that members are informed of specific follow-up healthcare needs and that members receive training in self-care that includes medication adherence and other measures that promote member health
- Ensure that members receive necessary appropriate specialty, ancillary, emergency and hospital care
- Provide necessary referrals and communication to specialists, hospitalists, SNFs and other providers
- Provide information that assists in member understanding and choice regarding consultation and recommending treatments, equipment and/or member services
- Provide coordination of care for members who are homebound or have significant mobility limitations to ensure access to care through home visits by nurse practitioners or physicians
- Track and document member appointments, clinical findings and treatment plans to ensure continuity of care from referred specialists, other healthcare providers or agencies
- Obtain authorizations and notify Humana of any out-of-network services when a participating specialty provider is unavailable in the geographic area
- Arrange, with Humana's care coordination team, for member-requested second opinion examinations with qualified in-network healthcare professionals. Also provide member help with arrangement for a second opinion visit with a non-participating provider, if no in-network provider is available
- Initiate or assist with member discharge or transfer from an inpatient facility to the most medically-appropriate level of care facility or the member's permanent home. Consider the availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities
- Cooperate and communicate with other member service providers. Such providers may include Supplemental Nutrition Programs for Women, Infants and Children (commonly referred to as "WIC" programs), Head Start programs, early intervention programs and school systems. Such cooperation may include performing annual physicals for school and sharing information with member consent
- Support and communicate with the ICT (in person and/or writing), in developing and implementing an individualized plan of care to facilitate effective care coordination
- Provide timely access to medical records or information for quality management and other purposes, including audits, reviews of complaints or appeals, HEDIS, and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate
- Follow the preventive care guidelines set by the U.S. Preventive Services Task Force, and provide and document the preventive care services required by the NCQA for HEDIS Quality Assurance Reporting Requirements
- Acknowledge that out-of-network or other authorizations are limited to the terms of the authorization as part of the member's ongoing course of treatment in accordance with continuity-of-care guidelines consistent with state requirements
- Adhere to preauthorization and referral processes and procedures
- Within 24 hours of discharge from an inpatient facility, transmit the transition record (discharge instructions) to the facility, primary care provider or other healthcare professional designated for follow-up care, including the diagnosis, treatment and care plan

NOTE: For members other than those who reside in nursing facilities:

- The member maintains his or her current providers for 180 days from the effective enrollment date, or 90 days if changing health plans
- During the 180-day transition period, the member's existing provider may be changed,
- but only if:

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

Out-of-network providers

The out-of-network physician must agree to:

- Accept reimbursement at Humana's established rates based on a review of the level of services provided
- Adhere to Humana's QA requirements
- Provide necessary medical information related to healthcare
- Adhere to Humana's policies and procedures, including procedures regarding referrals.

If the physician of a new member in the midst of an active, ongoing course of treatment or in the third trimester of pregnancy is not a participating provider, Humana will permit the member to continue receiving treatment with that physician for up to 90 days or through the postpartum period, or as otherwise required by Section 25 of the Managed Care Reform and Patients' Rights Act, only if the out-of-network physician agrees to provide the ongoing course of treatment.

Provider creation and participation in individualized care plans (ICPs)

The individualized care plan is based on:

- Initial and ongoing health risk assessments (HRA) and comprehensive assessment results
- Claims history
- ICT-developed member plans
- Inclusion of member-driven short- and long-term goals, objectives and interventions
- Addressing of specific services and benefits
- Provision for measurable outcomes

The ICT is a team of caregivers from different professional disciplines who work together to deliver care plan services that optimize quality of life and support of the member and his or her family.

Provider participation is an integral part of the ICT. Other team members may include:

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

The physician-inclusive ICT model supports the following:

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

Illinois law allows for the following two types of advance directives: designation of a healthcare power-of-attorney and creation of a written healthcare directive, also known as a living will. Providers should ensure that members are informed of these rights.

Expected provider communications and reporting responsibilities:

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

NOTE: Additional member information will be added regarding care plans, assessments and member summaries and made available in the provider's section of Humana's website.

Working with Demonstration members with a mental health diagnosis:

- Facilitate appropriate member referral to specialists or specialty care, behavioral healthcare services, health education classes and community resource agencies.
- Integrate medical screening along with basic primary care services provided to Demonstration members
- Provide screening and evaluation procedures for referral, detection and treatment of any known or suspected behavioral health problems and disorders
- Deliver evidence-based behavioral health treatment and establish referral protocols for behavioral health specialty providers
- Ensure confidentiality of members' medical and behavioral health and personal information as required by state and federal laws

Understanding chronic conditions prevalent within the Demonstration population:

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

Importance of coordinating both Medicare and Medicaid benefits, including information on LTSS Medicaid benefits:

- Member-centered, coordinated care – Person-centered and collaborative care, managed by a team with knowledge about specific member needs and the array of medical, nonmedical and behavioral services and benefits available to meet those needs are critical to helping members achieve their optimum level of wellness.
- Many dual-eligible members require a broad range of LTSS and community support to meet their functional needs. Effective coordination, administration of and easy access to LTSS benefits help ensure that these needs are adequately met and reduce the reliance on less appropriate and more costly emergency or hospital-based care.
- Demonstration members are faced daily with a variety of life challenges. Humana aims to eliminate the challenges and frustration of navigating a complex healthcare system by integrating a variety of administrative process for members and providers.

Provider disputes

Provider disputes submitted to Humana

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. However, the process and method to submit a dispute depends upon whether the dispute primarily involves long-term care or behavioral health services.

Non-behavioral health provider disputes

Providers may submit disputes online or by contacting Humana via telephone, written correspondence, or fax.

Online

Provider disputes about finalized claims can be submitted online via Availity Essentials. To begin, use the Claim Status tool to locate the claim and click the "Dispute Claim" button. Then go to the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana. Status and high-level Humana determination for disputes submitted online can be viewed in the Appeals worklist. For training opportunities, visit Humana.com/ProviderWebinars.

Telephonic

Provider disputes may be submitted telephonically by calling the following number: **800-787-3311** between 7 a.m. to 7 p.m. Central time, Monday through Friday.

Mail

Provider disputes submitted in writing need to be sent to the following address:

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

Fax

Provider disputes may be submitted via fax to the following number: **888-556-2128**

Please note, provider disputes containing a request for reconsideration should include the following documentation:

- A copy of the original claim
- The remittance notification showing the denial
- Any clinical records and other documentation that support your case for reimbursement

Humana is required to assign the provider a MCO Tracking Number for each complaint submitted through the Humana internal dispute process. Telephonically submitted disputes may not generate a reference number if the dispute is resolved during the call. However, disputes submitted online or via mail or fax will always generate a reference number. Please note, allow two – three business days for a tracking number to be generated for a faxed or online dispute prior to calling Humana in the event you are unable to locate an MCO Tracking Number, to account for required system generation timelines.

Humana's provider complaint tracking number consists of a 12-13 character alphanumerical code.

If you do not know or are unable to locate the MCO Tracking Number, providers can call Humana Provider Services at **800-457-4708** between 7 a.m. to 7 p.m. Central time, Monday through Friday. Once the case is located, the Humana Provider Services representative will give you the MCO Tracking Number.

In addition, refer to the outcome letter (sample below) that Humana sent in response to the claim dispute. Find the MCO Tracking Number [Reference ID] in the header of the outcome letter.

Humana.
Humana Health Care Plans
P.O. BOX 14601
Lexington KY 40512-4601

[DATE]

N/A N/A
1234 LOOKUP LANE
TAMPA FL 33611

Patient name:	John Doe
Member ID number:	H0000000
Group number:	xxxx
Claim number(s):	987654321
Patient date of birth:	01/01/0001
Reference ID:	0123456789
Reference ID:	123456789
Humana entity:	hmp
Account number:	0000
Provider name:	N/A

Behavioral health provider disputes

Providers may submit disputes for behavioral health claims by contacting Humana via telephone, email, or fax.

Telephonic

Provider disputes may be submitted telephonically by calling 855-481-7044 between 7 a.m. to 6 p.m. Central time, Monday through Friday

Email

Provider disputes submitted in writing need to be sent to SoutheastServiceCenterPR@beaconhealthoptions.com

Fax

Provider disputes may be submitted via fax to the following number: **305-722-3013**

Telephonically submitted disputes will not automatically generate a reference number if Provider Relations is able to address provider's complaint while on the phone. However, a complaint tracking number can always be generated and given to the provider if requested.

For disputes received via email, Provider Relations will respond back to the provider with the MCO tracking number.

If a dispute is received via fax and includes the provider phone number, Provider Relations staff will call the provider to provide them with the MCO Tracking Number. If a phone number was not included, Provider Relations staff will send a fax back acknowledging the receipt of the faxed dispute and include the MCO tracking number.

The reference number for behavioral health related complaints is 15 numeric characters in length, separated by a dash after the eighth digit. The first eight characters of the reference number denote the date the dispute was received and the following seven characters are randomly generated numbers. The format of the reference number is as follows: **MMDDYYYY-1234567**

If you do not know or are unable to locate the MCO Tracking Number for a dispute regarding a behavioral health claim, Providers can call Carelon Provider Services at 855-481-7044. Once the case is located, the Provider Services representative will give you the MCO tracking number.

In addition, refer to the complaint acknowledgement letter (sample below) that was sent in response to the claim dispute. Find the MCO tracking number (reference ID) in the header.

Provider disputes submitted to HFS

Providers have the capability to submit complaints regarding unresolved issues with MCOs via the HFS Managed Care Provider Resolution Portal implemented on February 28, 2020. Complaints are received via the new secure web-based Provider Resolution portal. MCOs are responsible for the timely and complete resolution of provider complaint tickets that are logged into the HFS Provider Resolution Portal. Visit the HFS provider portal at the following link to file a complaint: illinois.gov/hfs/MedicalProviders/cc/Pages/ManagedCareComplaints.aspx

Disputes cannot be submitted through the HFS provider portal earlier than 30 calendar days after submitting the complaint to Humana, nor can they be submitted any later than the following:

- 30 calendar days after unsatisfactory resolution, and/or
- 60 calendar days after the provider submits the dispute to Humana for internal resolution

All HFS provider complaint portal submissions must include the MCO-assigned tracking number and the date the complaint was filed with Humana's internal dispute resolution process. The provider must enter this MCO-assigned tracking number in the HFS Provider Resolution portal when submitting the complaint ticket. If you have the MCO Tracking Number, you may file your HFS complaint. If applicable, include the date the provider received the MCO resolution. The HFS provider portal will present the dispute to Humana. Humana will have 30 calendar days from the complaint receipt date to issue its written proposal to resolve the dispute, unless Humana is granted a five or ten day extension by HFS.

Providers must use the new standard complaints/claims-issue template when submitting two or more of the same or similar complaints with Humana. Providers are limited to a maximum of 100 similar complaints/claims on a template. When submitting a template, providers should not mix complaints/claims from different MCOs or different providers/facilities. Separate complaints/claims should be filed, with separate templates for each unique provider/facility (by Medicaid tax ID and location address).

MCOs must communicate directly with the provider to address the issue. When a MCO requests additional information from a provider, the provider must provide the additional information or demonstrate that this information was already provided to the MCO. HFS may grant up to a 14 calendar day extension if requested by the enrollee or the MCO shows that there is need for additional information and that the delay is in the enrollee's interest. Incomplete complaints or lack of response by the provider will cause the complaint to be closed in the portal.

If complaints cannot be resolved, HFS will make a final decision. The HFS decision on all disputes shall be final.

Grievance and appeals system

The section below is taken from Humana's Member Grievance and Appeals procedure as set forth in the Humana Member Handbook. This information is supplied to providers to help them assist Humana members with this process, if requested. Please contact your network management consultant with questions about this process.

Humana representatives handle all member grievances and appeals. Records of all grievances and appeals are kept for 10 years, with the reason, date and results.

Filing a grievance or appeal

Members with plan questions or issues may contact Member Services at **800-787-3311**. A grievance can be filed when the member is dissatisfied with Humana or any aspect of care. An appeal can be filed if the member disagrees with a coverage decision.

Grievances and appeals can be filed orally or in writing.

A provider or other authorized person may help the member during the grievance or appeal process.

A written grievance or appeal must include the following:

- Member's name, address, telephone number and Humana ID number
- Facts and details regarding the issue and the requested outcome
- Requestor's signature and date. If the requestor is not the member, additional documentation, such as a waiver or appointment of representative (AOR), may be required.

Grievance: The member has the right to file a written or verbal grievance at any time. The grievance process may take up to 30 calendar days, but Humana will resolve the member's grievance as quickly as required by the member's health condition. A letter advising the grievance outcome will be sent to the member or authorized representative within 30 calendar days from the date Humana received the request.

Appeal: The member has the right to file a written or verbal appeal within 60 calendar days of the date a written denial is received. The appeal process will take no more than 15 business days, but Humana will resolve the appeal as quickly as the member's health condition requires. A letter advising the appeal outcome will be sent to the member or the member's authorized representative within 15 business days from the date Humana received the request.

If more time is needed, the member and Humana must agree to an extension. If other information is needed, Humana will have 14 extra days to make a decision. Humana will send the member a letter informing them of the extension, and what to do if they disagree. The member has the right to continue services during the appeal and Medicaid fair hearing process. If the member chooses to continue the services and the decision of the appeal is not in the member's favor, the member may have to pay for those services.

NOTE: The Humana appeal process must be exhausted before requesting a Medicaid state fair hearing.

Expedited appeal process: The member, provider or authorized representative can request a verbal or written expedited appeal. If the member's life or health is in danger, the member or his or her legal spokesperson can file an "urgent" or "expedited" appeal. These appeals are handled within 24 hours of receipt of all the information required to work the appeal.

An expedited appeal can be requested by calling Humana Customer Care at **800-787-3311**. If you cannot hear or have trouble talking, call 711. Our hours of operation are 8 a.m. to 8 p.m. Monday through Friday.

If it is determined that it does not meet expedited criteria, it will go through the standard appeal process.

To send a grievance or appeal request in writing, please send it to the following address:
Humana Medical Plan Inc.
Attn: Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546

Providers appealing a claim on behalf of a member may also do so online via Availity Essentials. To begin, use the Claim Status tool to locate the claim and click the "Dispute Claim" button. Then go to the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana. Status and high-level Humana determination for appeals submitted online can be viewed in the Appeals worklist. For training opportunities, visit Humana.com/ProviderWebinars.

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

All operation hours are local time.

Chronic and complex conditions

Comprehensive diabetes care

Diabetic retinal examinations – Humana is committed to reducing the incidence of diabetes-induced blindness in Humana members. Early intervention and continual monitoring of diabetic eye disease could reduce the incidence of diabetes-related blindness. Based on guidelines proposed by the American College of Physicians, the American Diabetic Association, and the American Academy of Ophthalmology, the Humana PCP will provide or manage services such that recipients with a history of diabetes will receive at least one funduscopic exam every 12 months.

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

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

Nephropathy – The Humana PCP nephropathy screening is designed to delay or prevent loss of renal function through early detection and initiation of effective therapies, and to manage complications in those identified with a renal disease. The PCP manages the member by identifying evidence of a positive test for protein in the urine (micro-albuminuria testing). Member is to be monitored for the disease, including end-stage renal, chronic renal failure and renal insufficiency or acute renal failure and referred to a nephrologist as needed.

Congestive heart failure – Humana is aware that today there are effective options for treating heart failure and its symptoms. Humana recognizes that with early detection, symptoms can be reduced, allowing many heart failure patients to resume normal, active lives. To further these goals, the Humana PCP will provide or manage care of

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

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

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

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

HIV/AIDS – Humana requires that PCPs assist members in obtaining necessary care in coordination with Humana Health Services staff. Please contact Provider Services at **800-787-3311** or your provider contract representative for more details.

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

PCP and other provider/subcontractor responsibilities

Access to care

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

- Urgent care – Member must be provided an appointment within one business day when medically necessary.
- Routine sick member care – A Member shall be seen within three weeks from the date of the request.
- Well care and routine visits – Member must be provided an appointment within five weeks of making a request.
- Problems or complaints not deemed serious – Member must be provided an appointment within three weeks of making a request.

Initial prenatal visits without expressed problems:

- First trimester – Member must be provided an appointment within 14 calendar days of the request.
- Second trimester – Member must be provided an appointment within seven calendar days of the request.
- Third trimester – Member must be provided an appointment within three calendar days of the request.

Patient-centered medical home (PCMH) – Participating PCMHs are required to manage and provide evidence-based services to members in order to integrate care with specialty and subspecialty practices. The medical home is required to adhere to the following:

- Enhance access and continuity. Accommodate member needs with access and advice during and after hours, give information to patients and their families about their medical home and provide members with team-based care.
- Identify and manage patient populations. Collect and use data for population management.
- Plan and manage care. Use evidence-based guidelines for preventive, acute and chronic care management, including medication and mental health management.
- Provide self-care support and community resources. Assist members and their families with self-care management with information, tools and resources.
- Track and coordinate care. Track and coordinate tests, referrals and transitions of care.
- Measure and improve performance. Use performance and patient experience data for continuous quality improvement

For more information on how your practice can become a patient-centered medical home, contact Humana Illinois Provider Contracting at **800-787-3311**.

Americans with Disabilities Act compliance

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

Providers are required to comply with all ADA requirements, including:

- Use of waiting room and exam room furniture and accessible routes to and through rooms that meet needs of all members, including those with physical and nonphysical disabilities.
- Use of clear signage throughout provider offices. Adequate handicapped parking also is required.

If you have members who need interpretation services, either the provider or member can call the number on the back of their member ID card or visit Humana's website at Humana.com/accessibility-resources.

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

Member special needs consideration

Providers make efforts to understand the special required member needs. Member challenges may include physical compromises as well as cognitive, behavioral, social and financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease, isolation, depression, and polypharmacy are among daily challenges facing some members.

In recognition of those significant member needs, Humana incorporates all principles of either multi-disciplinary integration and person-centered care planning, coordination and treatment into our care coordination program.

- Integrated care management is delivered within an ICT structure and holistically addresses the individual member.
- The member and/or authorized caregivers are maintained at the model-of-care core, which ensures person-centered and supported self-care.
- Each member is assigned a care coordinator who leads the member's ICT and links closely to the members' PCP. The coordinator's goal is to ensure that members get needed full-spectrum care that includes medical, behavioral health and long-term care services.
- Based on claims history and analytics, Humana's predictive model determines appropriate risk and intervention levels before channeling the member to the required level of coordination.
- The Medicare Domain Assessment Tool (mDAT), a scored and weighted assessment tool, produces a clinically sound profile of the member's health status.
- The mDAT provides an overall risk score which, when combined with the predictive model score, is used to direct interventions targeted to impactful concerns. The member is encouraged to participate in all aspects of care management and coordination, including in the development of an individualized care plan.
- The care coordinator and ICT ensure that the member receives any necessary assistance and accommodations, including those mandated by the ADA, to fully participate in care planning throughout the management process.

The team also assures that the member receives clear information about:

- His or her health conditions and functional limitations
- How family members and social supports can be involved (as the member chooses) in member care planning
- Self-directed care options and assistance
- Opportunities for educational and vocational activities
- Available treatment options, supports and/or alternative courses of care

Identifying care barriers encountered by the Demonstration population

- Different programs with diverse coverage and payment structures impact delivery of integrated care due to poor coordination of services and benefits resulting in fragmented care that isn't focused on the member's needs.
- Shortage of health professionals in rural areas and inner cities affects easy access by Demonstration members to quality and cost-effective care and preventive services.
- Organizational barriers, including lack of interpreter services, wheelchair accessibility and long appointment wait times can cause frustration and, potentially, result in member refusal to seek and participate in care.
- Lack of coordination between behavioral health and other medical and non-medical services
- Cultural and religious beliefs impact member health beliefs and behaviors, including provider relationships and compliance to recommended treatments.

- Socioeconomic status may present issues related to poor education and lack of knowledge and support. The status affects a variety of concerns, such as awareness of available health options and support, reinforcement of healthy behaviors and ability to pay out-of-pocket.
- A member's lack of permanent residence can impact the ability of care providers to engage and provide member education and support.

Family planning services

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

Immunizations

Member immunizations should be provided in accordance with the Recommended Adult Immunization Schedule for the United States, or when medically necessary by the physician.

TABLE 1-2 ADULT PRVENTATIVE HEALTH EXAM AND SCREENINGS (beginning at 21)

ELEMENTS	GUIDELINES
Risk screening	Screening to identify high-risk individuals are included at a minimum: • Cardiovascular disease • HIV/AIDS • Tuberculosis (TB) • Hepatitis • Sexually-transmitted diseases (STDs)
Interval history	Preventive healthcare requires interval histories. Changes in medical, emotional and social status are documented.
Immunizations	Documented and current immunizations. (If immunization status is not current, document a catch-up plan. Immunizations are required as follows: • Influenza (annually) • Tb booster (every 10 years) • Pneumococcal vaccine (beginning at age 65) **NOTE:** If a member received a pneumococcal vaccination prior to age 65 and five years have since elapsed, he or she should be revaccinated.
Height and weight	Required documentation of height and weight for all preventive healthcare visits and at least: • Every five years (for ages 21 – 40) • Every two years (age 41 and older)
Vital signs	Required pulse and blood pressure checks are required for all preventive healthcare visits and at least: • Every five years (for ages 21 – 40) • Every two years (age 41 and older)
Physical exam	Appropriate evaluation for inclusion in the baseline physical examination of an asymptomatic adult are: • General appearance • Abdomen/GI • Eyes/ears/nose/throat • Neurological • Cardiovascular • Breasts • Gums/dental/oral • Musculoskeletal • Chest/lungs • Skin • Genital/urinary • Neck/thyroid • Lymphatic If member non-compliance or refusal is documented, the risk associated with the non-compliance also must be documented.

TABLE 1-2 ADULT PRVENTATIVE HEALTH EXAM AND SCREENINGS (beginning at 21)	
ELEMENTS	**GUIDELINES**
Cholesterol screening	Screening required every five years for: • Men – beginning at age 35 • Women – beginning at age 45 **NOTE:** Screening should take place earlier if there is any risk factor evident for cardiovascular disease)
Visual acuity testing	Visual acuity testing, at a minimum, documents the patient's ability to see at 20 feet. Testing referrals must be documented.
Hearing screening	Hearing test annually or as medically indicated.
Electrocardiogram	Periodically after age 40-50, or as primary care provider deems medically appropriate
Colorectal cancer screening	Documented colorectal cancer screenings beginning at age 50. Risk factors: • First-degree relatives or personal history of colorectal cancer • Personal history of female genital or breast cancer • Familial adenomatous polyposis • Gardner's syndrome • Hereditary nonpolyposis colon cancer • Chronic inflammatory bowel disease
Pap smear	Baseline pap smears annually for three consecutive years until three consecutive normal exams are obtained; then every two to three years. Exams may stop at age 65 if patient regularly has had normal smears up to that age.
Mammography	Required as appropriate between ages 35 and 40. • Every one to two years for women 40 or older • Earlier and/or more frequent for women at high-risk
Education/anticipatory	Health education and guidance must be documented. Guidance or educational needs are based on risk factors identified through personal and family medical history and social and cultural history and current practices.
Osteoporosis	Required screening for women 65 and older (begin at 60 if at increased risk for osteoporotic fractures). Perform a bone-density scan (DEXA Scan) for serial monitoring every two years; special conditions may need more frequent monitoring. All peri-menopausal women should have a DEXA Scan after sustaining a fracture, if test has not been recently performed.

Hysterectomies, sterilizations and abortions

Providers must maintain a log of all member hysterectomy, sterilization and abortion procedures. The log must include, at a minimum, the member's name and identifying information, date of procedure and type of procedure. The provider should provide abortions only in the following situations:

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

Termination of pregnancy shall not be provided to Enrollees who are eligible under the State Children's Health Insurance Program ((215 ILCS 106)

Providers must complete the following forms and file in member's medical record:
Acknowledgement of receipt of hysterectomy information – HFS form 1977
Abortion payment application – HFS form 2390
Sterilization consent form – HFS 2189

Pregnancy-related requirements

Licensed prenatal healthcare professionals must educate women and (if permitted and possible) families about perinatal behavioral health disorders. Providers should invite women to complete an assessment questionnaire using an approved instrument such as the Edinburgh Postnatal Depression Scale, to identify any perinatal behavioral health disorders.

Providers are expected to remind women of the importance of a postpartum exam and development of a reproductive plan that includes birth control. Providers should promote regular preventive care through annual preventive health and family planning visits. Providers must offer HIV testing and should offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at 28 to 32 weeks.

If a pregnant woman declines an HIV test, providers must attempt to obtain a signed objection form. All HIV-infected pregnant women should be counseled about and offered the latest anti-retroviral regimen recommended by the U.S. Department of Health and Human Services. Providers must screen all pregnant members receiving prenatal care for the hepatitis B surface antigen ("HBsAg") during the first prenatal visit.

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

- Member's name and date of birth
- Race
- Ethnicity
- Address
- Infant contacts
- Date laboratory test performed
- Date of sample collection
- Due date or estimated date of conception (EDC)
- Whether the member received prenatal care

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

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

- Prenatal care – providers are expected to:
  - Require a pregnancy test and a nursing assessment with referrals to a physician, physician assistant or advanced practice nurse (APN) for comprehensive evaluation
  - Require case management through the gestational period, according to member needs
  - Require any necessary referrals and follow-up
  - Contact those members who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care
  - Schedule return prenatal visits at least:
    - Every four weeks until the 32nd week
    - Every two weeks until the 36th week
    - Every week thereafter until delivery, unless the member's condition requires more frequent visits
  - Assist members in making delivery arrangements, if necessary
  - Ensure that all pregnant members are screened for tobacco use and make available any necessary smoking cessation counseling and appropriate treatment.
- Nutritional assessment/counseling – Providers should supply nutritional assessment and counseling to all pregnant members. In addition, providers are expected to:
  - Ensure the provision of safe and adequate nutrition for infants by promoting breastfeeding and the use of breast milk substitutes
  - Offer a mid-level nutrition assessment
  - Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment
  - By counselor name, document the nutrition care plan in the member's medical record.

Providers are required to immediately notify Humana of a member's pregnancy by calling Member Services at **800-787-3311**, whether identified through medical history, examination, testing and claims or otherwise.

If a member becomes pregnant while on the health plan, ask her to call the Member Services phone number on the back of her Humana identification card. The program will help choose a Humana obstetrician for her care, and make an appointment to see that doctor as soon as possible.

Other plan services include:

- Obstetrical delivery – The health plan shall develop and use generally accepted and approved protocols for both low- and high-risk deliveries reflecting the highest professional medical standards. In addition to the Healthy Start Program and prenatal screening, all providers must ensure the following:
  - Medical record documentation of member's preterm delivery risk assessments by week 28.

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

- Postpartum care – The health plan shall:
  - Provide a postpartum examination for the member within six weeks after delivery.
  - Ensure that providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate.

Domestic violence, alcohol and substance use, and smoking cessation

PCPs should screen members for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies. See Quality Enhancement section.

Member should be screened for signs of alcohol and substance use as part of a prevention evaluation:

- Upon initial member contact
- During routine physical examinations
- During initial prenatal contact
- When the member shows evidence of over-utilization of medical surgical, trauma or emergency services
- When documentation of emergency room visits becomes necessary

Regarding smoking-cessation, PCPs should educate members by:

- Helping them recognize the dangers of smoking
- Teaching them how to anticipate and avoid temptation
- Providing basic smoking cessation information
- Encouraging them to quit and talk about the quitting process

Quality improvement requirements

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

- **Quality Improvement Projects (QIPs)** – Ongoing measurements and interventions, significant quality of care improvement and service delivery in both clinical care and non-clinical areas, are expected to have a favorable effect on health outcomes and member satisfaction.
- **Medical record audits** – Annual medical record review conducted by EQRO to evaluate the quality outcomes concerning the timeliness of, and member access to, covered services.
- **Performance measures** – Data on patient outcomes as defined by HEDIS or otherwise defined by the agency.
- **Access to care audits** – Assembly of randomly selected provider pool to ensure appointment availability and after-hours answering service
- **Surveys** – Consumer Assessment of Health Plans Survey (CAHPS) and Provider Satisfaction Survey
- **Peer review** – Conducted by the plan to review provider practice methods, patterns and appropriateness of care.

If the quality improvement projects, CAHPS, performance measures, the annual medical record audit or the EQRO indicate unacceptable Humana performance, the agency may impose penalties.

Community outreach provider compliance

Providers:

- May display health plan-specific materials in their own offices
- Cannot – outside of providing confirmation of health plan participation – compare benefits or provider networks among health plans (either orally or in writing)
- May announce a new or changing health plan affiliation and give their patients a list of health plans with which they contract
- May not make Provider affiliation announcements that include marketing content.
- Communication with the enrollee will not be limited by Humana Healthy Horizons in Illinois
- May co-sponsor events, such as health fairs and advertise with the health plan in indirect ways; such as television, radio, posters, fliers and print advertisement
- Shall not furnish lists of their Demonstration patients to the health plan with which they contract, or any other entity, or furnish other health plans' membership lists or provide assistance with enrollment to the health plan or assist with enrollment
- May distribute information about non-health-plan-specific state or local health, welfare and social services, but only if prospective member inquiries are referred to the health plan's member services department or the agency's choice counselor/enrollment broker.

Illinois Medicaid provider number

All providers must have a unique state Medicaid provider number that is obtained as part of enrollment in the State's IMPACT program and is in accordance with the agency guidelines.

National Provider Identifier (NPI)

Providers are required to have a National Provider Identifier (NPI) in accordance with Section 1173 (b) of the Social Security Act, as enacted by Section 4707 (a) of the Balanced Budget Act of 1997.

Provider education of compliance-based materials

Providers are expected to adhere to all Humana-identified compliance-based training programs. This adherence includes a completed attestation to agreement by all participating providers and staff members trained on compliance material. The training includes the following required annual training modules:

- Humana orientation
- Medicaid provider orientation
- Cultural competency
- Health, safety and welfare education
- Fraud, waste and abuse and general compliance

Online training modules

Providers and their office staff can access these online training modules 24 hours a day, seven days a week at the Availity Provider Portal at Availity.com. Providers also can manually complete the training by visiting Humana.com/providercompliance.

Additional provider training: Visit Humana.com/providers and choose "Web-based Training Schedule"

NOTE: Directions for accessing general compliance and fraud, waste and abuse training can be found at Humana.com/fraud. Providers and their office staff can access these online training modules seven-days-a-week, 24 hours-a-day. If you are unable to access the internet, please call Humana's Provider Relations department at **800-626-2741** for copies of printed materials.

For long-term-care services and behavioral health providers, please see long-term-care services and Behavioral Health manual sections for contact information and help in accessing this required training.

Requirements regarding community outreach activities and marketing prohibitions:

- In accordance with 42 CFR 438.104(b)(1)(iv), Humana and its subcontractors shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
- In accordance with 42 CFR 438.104 (b)(1)(v), Humana and its subcontractors shall not, directly or indirectly, engage in door-to-door, telephone, or other cold-calling marketing activities.
- In accordance with 42 CFR 438.104 (b)(2)(i), Humana and its subcontractors shall not directly make any assertion or statement (whether written or oral) that the beneficiaries must enroll with Humana to obtain Medicaid state plan benefits or to retain Medicaid state plan benefits.
- In accordance with 42 CFR 438.104 (b)(2)(ii), Humana and its subcontractors shall not make any inaccurate false or misleading claims that Humana is recommended or endorsed by any federal, state or county government, the agency, CMS, department, or any other organization which has not certified its endorsement in writing to Humana.

NOTE: Providers must notify Humana of member's hospice status immediately upon discovery.

Medical record standards

For each MMAI member, the provider should maintain detailed and legible medical records that include:

- Member's identifying information including name, member ID, date of birth, sex and details of legal guardianship (if any)
- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications
- Description of chief complaint or purpose of visit, the objective diagnosis, medical findings of provider impressions
- Identification of any studies ordered and any referral reports
- Identification of any therapies administered and prescribed
- Name and profession of the provider rendering services, including the signature or provider initials
- Member disposition, recommendations and instructions, and evidence of any follow-up and service outcomes
- Immunization history
- Information relating to the member use of tobacco products and alcohol/substance use
- Summaries of emergency services, care and hospital discharges with appropriate follow-up
- Documentation of referral services and member medical records
- All services provided by provider (family planning services, preventive services, etc.)
- Primary language spoken by the member and any member translation needs
- Identify members needing communication assistance in the delivery of healthcare services
- Documentation that member was provided written member rights information that includes details advance directives and confirmation that the member has received the advanced directive information

Claims submission protocols and standards

Submitting an electronic claim

Healthcare professionals and facilities can use the Availity Portal and electronic data interchange (EDI) services as no-cost solutions for submitting claims electronically. To register for the Availity Portal or to learn more about Availity claims solutions, visit Availity.com.

Waystar, a ZirMed and Navicure company, offers healthcare providers no-cost solutions for electronic claims submission. In addition, Waystar's auto-adjudication tool checks claims for accuracy more quickly than a manual review. To get started, visit ZirMed.com.

Healthcare providers also may file a claim by EDI through the clearinghouse of their choice. Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for information.

If submitting a claim to a clearinghouse, use the following payer IDs for Humana:

- Claims: 61101
- Encounters: 61102

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

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

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

Timely Provider Payments

For claim payment inquiries or complaints, please contact Humana Customer Care at **800-787-3311** or your network management consultant.

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

Humana will make provider payments (including the fiscal agent making payments to personal assistants under the HCBS waivers for covered services) on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a. Payment complaints or disputes for the provision of services are subject to Humana's provider dispute process.

Humana will pay 90% of all clean covered provider service claims within 30 days following submission receipt. Humana will pay 99% of all clean covered provider service claims within 90 days following submission receipt.

Regarding member admission to a nursing facility, a clean claim means that the admission is reflected on the patient's credit file that Humana receives from the state.

Cultural competence

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

Culture impacts patient care by informing:

- Concepts of health and healing
- How illness, disease, and their causes are perceived

Culture impacts every healthcare encounter.

- Who provides treatment?
- What is considered a health problem?
- What type of treatment?
- Behaviors of patients who are seeking healthcare
- What care is sought?
- How are symptoms expressed?
- How well are rights and protections understood?
- Attitudes toward healthcare provider

Clear communication

Limited English proficiency (LEP) describes how the degree to which a member's inability or a limited ability to speak, read, write, or understand the English language affects effective interactions between the member and healthcare providers or health plan members.

Health literacy

Health literacy describes a member's ability to obtain, process, and understand basic health information and services needed to make appropriate decisions. Over a third of patients experience limited health literacy, which results in a lack of understanding of what's required to care of their health.

Limited health literacy is associated with:

- Poor management of chronic diseases
- Poor understanding of and adherence to medication regimens
- Increased hospitalizations, and poor health outcomes

Humana develops member communications based on health literacy and plain language standards per the federal Plain Writing Act of 2010. The reading ease of Humana written member materials is tested using the widely recognized Flesch-Kincaid Readability tool.

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

Humana is committed to providing free language assistance services for its members with LEP.

This assistance includes:

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

Subcultures and populations

Subculture is a term that describes ethnic, regional, economic or social groups that exhibit characteristic behavior patterns that distinguish them from others within an embracing culture or society. Understanding the many different subcultures that exist within our own culture also is an important aspect of cross-culture healthcare.

To address the health issues within different ethnicities, providers must work to understand the values, beliefs, and customs of these different people. Some of the cultural aspects that may impact health behavior are:

- **Eye contact** – Many cultures use deferred eye contact to show respect. Deferred eye contact does not mean that the patient is not listening to you.
- **Personal space** – Different cultures have varying approaches to personal space and touching. Some cultures expect more warmth and hugging when greeting people.
- **Respect for authority** – Many cultures are very hierarchical and view doctors with a lot of respect. These patients may feel uncomfortable questioning doctors' decisions or asking questions.

Seniors and people with disabilities

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

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

Member rights and responsibilities

Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the Memorandum of Understanding (MOU) between CMS and the state.

Member rights

- The right to be treated with dignity and respect
- The right to be afforded privacy and confidentiality in all aspects of care and for all healthcare information, unless otherwise required by law
- The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records (as specified in 45 C.F.R. part 164)
- The right to receive information on available treatment options and alternatives that is presented in a manner appropriate to the enrollee's condition, functional Status, and language needs
- The right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment
- The right to have all plan options, rules, and benefits fully explained (including through use of a qualified interpreter if needed)
- Access to an adequate network of primary and specialty providers who are capable of meeting enrollee needs with respect to physical access, communication and scheduling needs. The providers are also subject to ongoing assessment of clinical quality including required reporting
- The right to receive a second opinion on a medical procedure and have the contractor pay for the second opinion consultation visit
- The right to choose a plan and provider at any time, including a plan outside of the demonstration, and have that choice be effective the first calendar day of the following month
- The right to have a voice in the governance and operation of the integrated system, provider or health plan, as detailed in this three-way contract
- The right to participate in all aspects of care and to exercise all rights of appeal. Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, enrollees must:

- Receive a comprehensive, in-person assessment upon plan enrollment and participate in the development and implementation of an individualized care plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of enrollee strengths and weaknesses and a plan for managing and coordination enrollee care. Enrollees or their designated representatives also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment
- Receive complete and accurate information on his or her health and functional status by the interdisciplinary team
- Be provided information on all program services and healthcare options, including available treatment options and alternatives, regardless of cost or benefit coverage, presented in a culturally appropriate manner, taking an enrollee's condition and ability to understand into consideration

- An enrollee who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
  - Before and during enrollment
  - Whenever potential or current enrollee needs necessitate the disclosure and delivery of such information in order to allow the enrollee to make an informed choice
  - That encourages caregiver or family member participation in treatment discussions and decisions
  - That explains and encourages advance directives, if the participant so desires, in accordance with 42 C.F.R. §§ 489.100 and 489.102
  - That provides reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
  - Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review
- The right to voice complaints or submit appeals about the organization or the care it provides
- The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Each enrollee is free to exercise his or her rights, and that the exercise of those rights will not adversely affect the way the contractor, its providers, the state or CMS provide or arrange for the provision of medical services to the enrollee
- The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the orientation materials at least once each year, and the right to receive notice of any significant information changes to orientation materials at least 30 days prior to the intended effective date of the change. See 438.10(g),(h)
- The right to be protected from liability for payment of any fees that are the obligation of the contractor
- The right not to be charged any cost sharing for Medicare Parts A and B services
- The right to make recommendations to the Enrollee Rights and Responsibilities statement

Member responsibilities

- A member is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to the member's health
- A member is responsible for reporting unexpected condition changes to the healthcare provider
- A member is responsible for notifying his/her PCP of any significant mobility limitations or homebound status that would warrant the need for PCP home visits
- A member is responsible for confirming his or her understanding of their health problems, a healthcare provider's possible course of action, member expectations and participating in developing mutually agreed-upon treatment plans to the degree possible
- A member is responsible for following the healthcare provider-recommended treatment plan they agreed to together
- A member is responsible for notifying a healthcare provider or healthcare facility if, for any reason, he or she is unable to keep an appointment
- A member is responsible for his or her actions when refusing treatment or not following healthcare provider instructions
- A member is responsible for assuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible

Fraud, waste and abuse (FWA)

Both the federal government and the individual states that are establishing and monitoring requirements for Medicare and Medicaid are trying to reduce fraud, waste and abuse (FWA) in the Medicare and Medicaid programs. Healthcare

FWA can involve physicians, pharmacists, members and even medical equipment companies. Success in combating healthcare fraud, waste, and abuse is measured not only by convictions, but also by effective deterrent efforts.

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

Telephonic:

- Special Investigations Unit Hotline: **800-614-4126**, 24/7 access
- Ethics Help Line: **877-5-THE-KEY (877-584-3539)**

Email:

- siureferrals@humana.com or ethics@humana.com

Web:

- Ethicshelpline.com

Key features of methods for direct reporting to Humana:

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

Confidentiality: Processes are in place to maintain confidentiality of reports; Humana allows confidential report follow-up. Humana strictly prohibits intimidation and/or retaliation against anyone who, in good faith, reports suspected or detected violation of ethical standards.

Additional information on this topic is included in the Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training document published by the Centers for Medicare & Medicaid Services (CMS).

NOTE: The concepts in the CMS document apply to all Humana lines of business. Please refer to subsection 8.14 of Section I for more detailed information and directions regarding how to access this required annual training.

Health safety and welfare

By law, providers must immediately report suspected abuse, neglect or exploitation risks to the appropriate state agency and the member's Humana ICT care manager.

This report includes, but is not limited to:

- **Abuse** – Non-accidental infliction of physical and/or emotional harm.
- **Physical abuse** – Causing the infliction of physical pain or injury.
- **Sexual abuse** – Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other disabled adult sexual activity; touching, fondling, sexual threats, sexually inappropriate remarks, or any other sexual activity with a person that is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity.
- **Psychological abuse** – Includes, but is not limited to, name calling, intimidation, yelling, and swearing; may also include ridicule, coercion and threats.
- **Emotional abuse** – Verbal assaults, threats of maltreatment, harassment, or intimidation intended to compel the person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the person wishes and has a right to engage.
- **Neglect** – Repeated conduct or a single incident of carelessness which results or could reasonably be expected to result in serious physical or psychological/ emotional injury or substantial risk of death (this includes self-neglect and passive neglect).
- **Exploitation** – Illegal use of assets or resources of an adult with disabilities; including, but not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion, or in any manner contrary to law.

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

Additional information on this topic is included in Humana's required health, safety and welfare education annual compliance training. Please refer to the information in Section I subsection Health safety and welfare for more detailed information and directions regarding how to access this required training.

Section II: Long-Term Care Support and Services (LTSS)

As an LTSS professional, you play a very important role in the delivery of healthcare services to the health plan members.

Overview

- The contractor (health plan) bears the underwriting risk of all services covered under contract.
- Services are to be provided in accordance with an individualized care plan developed by the health plan in consultation with the member and which will include services determined through an assessment by the health plan to be necessary to address the health and service needs of the member.

- The health plan may not require any copayment or cost sharing by members except the patient responsibility amount for nursing facility or supportive living facility services or any copayments established under state law for members of the Demonstration, or the state's Medicaid program.
- The health plan does not permit members to be charged for missed appointments.
- All services delivered to members by the health plan contractors (either directly or through a subcontract) must be guided by the following service delivery principles:
  - Services must be individualized as a result of a competent, comprehensive understanding of a member's multiple needs.
  - Services must be delivered in a timely fashion in the least restrictive, cost-effective and appropriate setting.
  - Long-term services and supports (LTSS) must be based upon a member's plan of care and include goals, objectives and specific treatment strategies.
- Services must be coordinated to address comprehensive needs and provide continuity of care.
- Services must be delivered regardless of geographic location within the service area, function level, cultural heritage and degree of member illness.
- The project's administration and service delivery system must ensure member participation in care planning and delivery, and, as appropriate, allowing for the participation of family, significant others, and caregivers.
- The contractor shall provide interpreter services (in-person, where practical, but otherwise by telephone) for members who do not speak English as a primary language. Annual agency-provided non-English versions of materials are required if the county population that speaks a particular non-English language exceeds 5%.
- Services must be delivered by qualified providers as defined by applicable contract.
- All facilities providing member services must be accessible to persons with disabilities, be smoke free and have adequate space, supplies, adequate sanitation, and fire and safety procedures per federal, state and local laws and regulations.

Managed care is an important part of enrolled member care coordination and service integration. The state contracts with a qualified contractor or heath plan for a program offering various features to the Medicaid consumer who is at risk of placement in a nursing home, or otherwise meets a Medicaid program qualification. This contractor will use LTSS providers such as supportive living facilities, adult day care, skilled nursing facilities, home health and personal care organizations in their network.

The Provider Relations Department is responsible for provider education, recruitment, contracting and new provider orientation. The Quality Management Department is responsible for monitoring quality and regulatory standards, and investigation of member complaints and grievances. The Provider Data Management Department presides over coordinating contract loads, demographic changes and provider terminations in the provider data management system.

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

Covered services

General services

Through its contracted providers, the Demonstration health plan is required to arrange for medically necessary services for each member. When providing covered services to plan members, the provider must adhere to applicable plan coverage provisions and all applicable state and federal laws.

TABLE 2-1 LTSS-COVERED SERVICES

(Waiver eligibility required, $0 member cost) Prior authorization and referral may be required

Specialized medical equipment and supplies

COVERED SERVICES: This service includes care plan-specific devices, controls or appliances that enable members to increase their ability to perform daily activities or perceive, control or communicate within their environment.

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

TABLE 2-1 LTSS-COVERED SERVICES

(Waiver eligibility required, $0 member cost) Prior authorization and referral may be required

Home modifications

COVERED SERVICES: The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include:

- Ramps
- Grab-bars
- Doorway widening

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

Adult day services

COVERED SERVICES: Adult day service provides a variety of social, recreational, health, nutrition and related support services within a protective daytime, community-based setting. Lunch and transportation to and from the center are included.

Available for members on the following waivers:

- Persons who are elderly
- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

Behavioral services

COVERED SERVICES: Therapy services designed to assist members with brain injuries manage behavior and thinking functions, and enhance their capacity for independent living

Available for members on the following waivers:

- Persons with brain injuries

Day habilitation

COVERED SERVICES: Provides independent living skills training (such as help with gaining, maintaining or improving self-help, socialization and adaptive skills).

This service also helps the member gain or maintain his or her maximum functional level.

Available for members on the following waivers:

- Persons with brain injuries

Home delivered meals

COVERED SERVICES: The plan covers prepared meals brought to your home if you qualify.

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

Home health aide

COVERED SERVICES: Member assistance with basic health services such medication dosing, nursing care, physical, occupational and speech therapy. A doctor's order is required.

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

Homemaker

COVERED SERVICES: Agency-provided assistance with housekeeping tasks such as meal preparation, shopping, light housekeeping and laundry.

The caregiver also can help with hands-on personal care items such as personal hygiene, bathing, grooming and feeding.

Available for members on the following waivers:

- Persons who are elderly
- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

TABLE 2-1 LTSS-COVERED SERVICES

(Waiver eligibility required, $0 member cost) Prior authorization and referral may be required

Skilled nursing (focuses on short-term, acute healing needs)

COVERED SERVICES: Home based, skilled-nursing services designed to help restore and maintain the highest member function and health levels.

These services are provided instead of a hospitalization or a nursing facility stay. A doctor's order is required.

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

Intermittent nursing (focuses on long-term needs)

COVERED SERVICES: Services include weekly insulin syringe or medicine dosage setup for members unable to manage these tasks themselves.

These services are provided instead of a hospitalization or a nursing facility stay. A doctor's order is required.

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

Personal assistant

COVERED SERVICES: Services that involve the hiring and management of an in-home caregiver by the member. The member must be able to manage employer responsibilities, such as management of the caregiver's time and timesheets, and completing other employee paperwork. The caregiver helps with housekeeping and personal tasks such as:

- Meal preparation
- Shopping
- Light housekeeping
- Laundry
- Personal hygiene
- Bathing and grooming
- Feeding

Personal assistants can include other independent direct caregivers such as RNs, LPNs and home health aides. Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

Physical, occupational and speech therapy

COVERED SERVICES: These services are designed to improve and/or restore a person's body function (includes physical therapy, occupational therapy, and/or speech therapy)

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

Prevocational services

COVERED SERVICES: These services are designed to provide work experiences, training and help in development of necessary general workforce skills. Includes teaching of concepts such as:

- Compliance
- Attendance task completion
- Problem-solving
- Safety

Available for members on the following waivers:

- Persons with brain injury

Respite

COVERED SERVICES: This service provides relief for unpaid family or primary caregivers who meet all daily member needs. The respite caregiver assists the member with all daily needs while the family or primary caregiver is absent, and can be provided by a homemaker, personal assistant, nurse or in an adult day services center.

Available for members on the following waivers:

- Persons with brain injury
- Persons with disabilities
- Persons with HIV/AIDS

Supported employment

COVERED SERVICES: Services involve activities needed to maintain paid work by individuals receiving waiver services, including supervision and training.

Available for members on the following waivers:

- Persons with brain injury

TABLE 2-1 LTSS-COVERED SERVICES

(Waiver eligibility required, $0 member cost) Prior authorization and referral may be required

Supportive Living Program

COVERED SERVICES: An assisted-living housing option that provides members with many support services needed to keep the member as independent as possible.

Service examples include:

- Housekeeping
- Personal care
- Medication oversight
- Shopping
- Social programs

The program does not offer complex medical services or supports.

Available for members on the following waivers:

- Supportive living facility

Out-of-network care for unavailable services

Upon notification of authorization from a referring provider, Humana will arrange out-of-network care if unable to provide necessary covered services or ensure the second opinion of a participating network provider.

Expanded services

Expanded services are those offered by Humana and approved in writing by the state. Such services are outlined in the benefit summaries below. For additional information, providers can call the customer service number provided on the back of the Humana member's ID card.

Care coordination and service authorization

Long-term services and supports (LTSS) service authorizations are done at the care coordinator (CC) level. Authorizations for Personal Emergency Response Services (PERS) must be submitted to the care coordinator. The CC completes a comprehensive assessment and works with the member to identify care needs and identify resources to meet those needs. The CC creates the LTSS authorizations and service plan during the visit. If care needs exceed the state provided service cost maximums, then the service authorization request is sent for the LTSS utilization management team review for medical necessity based on member care needs. Service denials or reductions are issued from the Medical Director. Providers can request LTSS services but all service authorization additions or changes must go through the care coordinator and be based on member assessment of needs. Please contact Humana LTSS care coordinator at HumLTSStransitions@humana.com to request LTSS services on behalf of a Humana-covered member.

Provider definition and status

The requirements for eligible providers of covered services are identified in the state Demonstration contract. Only licensed providers are eligible to provide services to plan members. The health plan will work with the guidelines and policies designed with the welfare and well-being of the member in mind.

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

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

- Any licensed LTSS provider may be authorized to provide voluntary services during an emergency, regardless of whether they have previously been contracted.
- To verify license status of a LTSS provider, online resources or a copy of the license may be used.

Provider contracting, application and credentialing

The LTSS provider has the responsibility of providing the necessary items for contracting.
All LTSS participating providers must be credentialed with the state of Illinois through the IMPACT system prior to their contract effective date with Humana and re-credentialed as the state requires. The provider contracting and credentialing policy is available through the Humana provider relations representative.

NOTE: General provider credentialing requirements can be found through the state's IMPACT website at illinois.gov/hfs/impact/Pages/default.aspx.

Noted time periods

- Applications must be completed within 180 days of receipt of provider signature.
- If a letter of agreement is used, it will have an expiration date and need to be replaced by full application and agreement.
- Out-of-network or other authorizations are limited to the terms of the authorization.

Provider policies and responsibilities

Equal Provider Opportunity

Humana is an equal opportunity organization. Provider participation decisions are non-discriminatory and based on merit and business needs, not race, color, citizenship status, national origin, ancestry, gender, sexual orientation, age, weight, religion, creed, physical or mental disability, marital status, veteran status, political affiliations or any other factor protected by law.

Affirmative Action, diversity and the Cultural Competency Plan

We are committed to embracing diversity in the provision of member services and providing fair and equal opportunities for all qualified minority businesses. The contractor tracks and reports information to applicable agencies regarding utilization of certified and non-certified minority contractors and vendors for all subcontractors and vendors receiving funds pursuant to all covered contracts. The health plan wishes to accommodate religious and cultural preferences of all members and will seek provider input that might be useful in meeting member preferences.

To request a paper copy of Humana's Cultural Competency Plan, please contact Humana customer service at **800-4HUMANA (800-448-6262)** or call your provider contracting representative. The copy of Humana's Cultural Competency Plan will be provided at no charge to the provider.

Americans with Disabilities Act

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

Contract, law and license compliance

Each provider application is contingent upon verification of the candidate's right to provide services. Every provider will be asked to provide documents that verify compliance.

Provider background checks

A background check may be applicable depending on provider type and service. A comprehensive background check may include prior provider verification, professional reference checks, education confirmation and Office of Inspector General list.

Criminal record check and criminal allegations

Most provider licenses require a criminal record check be performed prior to license issue. If possible, Humana will not duplicate such effort, but reserve the right to request a criminal record check to protect our interests and those of our clients and members.

Any report that implies criminal intent on the part of provider and is referred to a governmental or investigatory agency must also be sent to the state Medicaid agency. Humana will investigate allegations regarding falsification of client information, service records, payment requests and other related information. If Humana has reason to suspect the allegations have merit, they will be referred as required by federal and state mandates.

HIPAA standards

The task of handling member records and related administration functions is accomplished in strict compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Member files will be kept confidential at all times. Providers should take some or all of the

following precautions:

- Only request and work with protected health information (PHI) related to "treatment, payment or healthcare operations."
- Email should not be used to transfer files with member info unless the email is encrypted.
- Fax machines should be positioned for privacy.
- Fax numbers should be confirmed before sending information to Humana.
- Leave minimum data on voice mail.

Change of provider data

Any change in a provider's name, address, telephone number, or change of ownership, needs to be reported without delay to Humana Provider Relations online through Availity.com.

Provider education of compliance-based materials

Providers are expected to adhere to all training programs identified by Humana as compliance-based training. This includes agreement and assurance that all participating providers and staff members are trained on the identified compliance material. This training includes, but is not limited to, the following training modules:

- Provider orientation
- Medicaid provider orientation
- Cultural competency (required annually)
- Health, safety and welfare education (required annually)
- Fraud, waste and abuse detection, correction and prevention (required annually)
- Critical incident reporting
- Abuse, neglect, and exploitation
- Disability awareness and ADA
- Other Humana-specific training

For information about:

Humana's Cultural Competency Plan
Section I – General Provider Information

Humana's Health, Safety, and Welfare Training
Section I – General Provider Information

Humana's Fraud, Waste and Abuse Training
Section I – General Provider Information

Additional information on these topics is included in Humana's required annual compliance training. Please contact Humana Provider Relations for help in understanding how to access this required training by calling **800-787-3311 (TTY: 711)** Monday – Friday, 8 a.m. - 8 p.m. local time or visiting Availity.com or Humana.com/provider/news/provider-compliance.

Emergency service responsibilities

The health plan has an emergency management plan that specifies what actions the health plan shall conduct to ensure the ongoing provision of covered services in a disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies.

The health plan offers an after-regular-business-hours provider services line (not the prior authorization line) that is answered by an automated system that provides callers with information about:

- Operating hours
- Instructions for member enrollment verification
- Emergency or urgent medical conditions.

This shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

Weather-related and emergency-related closings

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

Quality improvement

Quality Improvement (QI) Program overview

Humana will monitor and evaluate the quality and appropriateness of – or failure to provide – member care and service delivery through:

- Quality Improvement Projects (QIPs) – Ongoing measurements and interventions, significant quality care and service delivery over time, in both clinical and non-clinical care areas, are expected to have a favorable effect on health outcomes and member satisfaction.
- Medical record audits – Annual medical record reviews are conducted by an external quality review organization (EQRO) to evaluate covered service outcome quality, in terms of timeliness and member accessibility.
- Surveys – Use of the Consumer Assessment of Health Plans Survey (CAHPS) and Provider Satisfaction Survey
- Peer review – Conducted by the plan to review a provider's practice methods, patterns and appropriateness of care.
- Performance measures – Data will be based on patient outcomes as defined by HEDIS or otherwise defined by the agency.

If the quality improvement projects, CAHPS, performance measures, annual medical record audit or the EQRO indicate that Humana's performance is unacceptable, the agency may impose penalties.

Standards of conduct

Stakeholder expectations

The LTSS provider is a problem-solver and member resource. The LTSS provider contributes to positive member outcomes through reference to a care plan and member collaboration when addressing self-management and wellness issues.

Stakeholders include:

- The LTSS provider
- The health plan/contractor

- The resident/member and their sponsors
- State and federal agencies and third-party healthcare providers

The contractor is a resource for the LTSS provider in meeting stakeholder expectations.

The Professional Case Management team is one heath plan benefit. The team develops a member care plan and will make appropriate care plan information available for LTSS provider use.

Your Humana agreement specifies appropriate service delivery scheduling guidelines in sections related to record keeping, policies and procedures and provider responsibilities attachments. The Humana agreement as a whole is relevant and referenced within the provider handbook. Please be sure to review.

The health plan has developed a monitoring process for service delivery scheduling versus actual member service wait times. When the service delivery scheduling or waiting times are excessive, the health plan must take appropriate action to ensure adequate service delivery. Each health plan contract will communicate its specific processes during Humana orientation as applicable and appropriate for the covered services you will provide.

Reporting significant member health outcomes

Facility and home health providers will provide notice to the health plan within 24 hours after an adverse event, such as member death, when a member decides to leave the facility against medical advice, and neglect, abuse, exploitation or fraud, which should be reported to regulatory authorities.

The LTSS provider also should report member changes in health outcomes to the health plan case manager. Such adverse events would include the following:

- Decline in member's health status due to medication management
- Significant worsening of activity of daily living (ADLs)
- Two or more behavioral health conditions
- Significant change in toileting ability
- Falls or accidents (with or without injury)
- All adverse health outcomes reporting, and reviews are part of the quality initiatives

Incident reporting

The provider must agree to implement a systematic process for incident reporting and immediately (or no later than 24 hours after occurrence) notify Humana of an incident that may jeopardize the health, safety and welfare of a member or impair continued service delivery. Reportable conditions include, but are not limited to:

- Closure of provider services or facilities due to license violations
- Loss or destruction of member records
- Compromise of data integrity
- Fire or natural disasters
- Critical issues or adverse incidents that affect a member's health, safety and welfare

The provider must ensure that each member is free to exercise his or her rights, and that exercising those rights does not adversely affect how the member is treated by providers, provider employees or affiliates.

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

Member transition to another network provider

Humana will help members transition to a new provider if their former provider leaves the health plan's network both during and after the transition period is over. This policy is addressed in Humana's Care Coordination Policies and Procedures Manual.

TABLE 2-2 MEDICARE-MEDICAID ALIGNMENT INITIATIVE (MMAI)

WAIVER SERVICES	Department of Aging	Department of Human Services – Division of Rehabilitation Services			Healthcare and Family Services
	Elderly	Disability	HIV/AIDS	Brain injury	Supportive living facility
Adult day service	X	X	X	X	
Adult day service transportation	X	X	X	X	
Environmental accessibility adaptations - home		X	X	X	
Supported employment				X	
Home health aide		X	X	X	
Nursing, intermittent		X	X	X	
Nursing – skilled (RN and LPN)		X	X	X	
Occupational therapy		X	X	X	
Physical therapy		X	X	X	
Speech therapy		X	X	X	
Prevocational services				X	
Habilitation-day				X	
Homemaker	X	X	X	X	
Home delivered meals		X	X	X	
Individual provider, including personal assistant (contingent upon compliance with collective bargaining agreement and accompanying side letter between SEIU and the state).		X	X	X	
Personal Emergency Response System (PERS)	X	X	X	X	
Respite		X	X	X	
Specialized medical equipment and supplies		X	X	X	
Behavioral services (M.A. and PH.D)				X	
Assisted living – Nursing services, personal care, medication management, including administration, social and recreational programming, health promotion and exercise programs, 24 hour response/ security, emergency call system, daily checks, laundry, housekeeping, maintenance, ancillary services					X

Medical necessity standards and practice protocols

Medically necessary services are those that include medical allied, or long-term care, goods or services furnished or ordered to:

- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs.
- Meet guidelines pertaining to the treatment of chronic and complex conditions including:
  - Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
  - Be reflective of the level of safely furnished services and what equally effective and more conservative or less costly treatment is available statewide
  - Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
  - Be furnished in a manner that does not give primary consideration to the convenience of the member, member's caretaker or the provider
- For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
- The fact that a provider has prescribed, recommended or approved medical, allied, or long- term care goods or services does not, in itself, make such care, goods or services medically necessary or a covered service or benefit.
- The health plan will have protocols, policies and procedures for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies). Some may be incorporated herein, while others will be identified in bulletins from the health plan. Guidelines pertaining to the treatment of chronic and complex conditions will be included in health plan bulletins.

Health plan implements MMAI Demonstration care plans

- The health plan care coordinator will perform an assessment on each new member to determine necessary individual services and supplies and review the current plan of care.
- Once the needed services or supplies have been identified, the health plan care coordinator will finalize the care plan. The health plan care coordinator and the LTSS provider may complete a type of care plan conference.
- Once the assessment and the care plan are completed, the health plan will send an Agreed Services Form or copy of service plan that would identify the member's care needs.

In accordance with Humana policy, it is the responsibility of the provider to submit all items necessary for claims processing.

Claims submission protocols and standards

Provider billing for services

Network providers shall provide services and supplies and receive payment in accordance with the contractual agreement with the managed care plan.

Instructions and required clean (complete) claim criteria

Providers shall submit a claim to managed care plan as applicable using the UB-04 or CMS-1500, or their successors billing form as applicable to providers and the program. Providers will be oriented and trained about the applicable process for their respective provider type.

Atypical provider (i.e. waiver services provider), should submit claims using your tax identification number and your Illinois Department of Healthcare and Family Services (HFS) Medicaid number. Do not include a National Provider Identifier (NPI) number. Please reference Illinois Association of Medicaid Health Plans (IAMHP) Comprehensive Billing Manual.

The following HFS provider types are considered Home and Community Based Services (HCBS) providers that can bill to Humana:

HFS Provider Type	HFS Description
090	Waiver service provider-Elderly (DoA)
092	Waiver service provider-Disability (DHS/DRS)
093	Waiver service provider-HIV/AIDS (DHS/DRS)
098	Waiver service provider-TBI (DHS/DRS)

To file a claim for Humana-approved services for one of the four HCBS waivers described above, waiver providers are required to register as a waiver provider with IMPACT. Many HCBS providers are considered "atypical" by HFS' IMPACT system. HFS IMPACT definition of an atypical provider is: "A provider who is delivering services to Medicaid clients that are not considered to be healthcare services. These providers are not required to obtain an NPI (National Provider Identifier). The Centers for Medicare & Medicaid Services (CMS) defines atypical providers as providers that do not provide healthcare. This is further defined under Health Insurance Portability and Accountability Act (HIPAA) in Federal regulations at 45 CFR 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and should not receive an NPI number."

Provider billing

We accept both electronic and paper claims submissions, but to assist in processing and paying claims efficiently, accurately, and in a timely manner, providers are strongly encouraged to submit claims electronically and support the process contractually. For example, electronic claim submissions are immediately processed through pre-import edits to evaluate the validity of the data, HIPAA compliance and member enrollment information.

Healthcare professionals and facilities can use the Availity Portal and electronic data interchange (EDI) services as no-cost solutions for submitting claims electronically. To register for the Availity Portal or to learn more about Availity claims solutions, visit Availity.com.

If submitting a claim to a clearinghouse, use the following payer IDs for Humana:

- Claims: 61101
- Encounters: 61102

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

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

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

Examples of acceptable paper claims forms

Completing a CMS-1500

The CMS-1500 billing form is used to submit paper claims for professional services. Humana requires providers to use the CMS-1500 billing form when submitting paper claims:

Before submitting a claim, a provider should ascertain that all required attachments are included. All claims that involve other insurance must be accompanied by an explanation of benefits (EOB) or a remittance advice (RA) that clearly states how the claim was paid or the reason for denial.

Completing the UB-04

The UB-04 form is used when billing for facilities services, including nursing home room and board, supportive living room and board, hospice and intermediate care facilities services.

Electronic claims submission

Humana is capable of receiving electronic claims submission. The acceptable formats include X12 5010 837 institutional, provider formats. Humana also allows for direct data entry (DDE) through Availity.com.

When filing an electronic claim, use payer ID 61101 for long-term care claims.

For questions on how to enroll in electronic claims submissions, please call **800-282-4548** or go to Availity.com.

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

Clean claim submission

Humana can only process clean claim submissions; unclean claims will not be processed and will be returned to the provider for correction. A clean claim is a submission that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.

The health plan shall reimburse providers for the delivery of authorized covered services as described in the mandates and the member's benefit plan. The provider must mail or electronically transfer (submit) the claim to Humana within 180 days of the date of service or discharge from an inpatient setting; or the date that the provider was furnished with the correct name and address of the health plan.

When Humana is the secondary payer, the provider must submit the claim to the health plan within 90 calendar days after the final determination of the primary payer, and in accordance with the Medicaid Provider General Handbook.

Claims payment time frames

Humana processes clean claims according to the following time frames: For electronic submissions, Humana will provide an electronic acknowledgment of the receipt of the claim.

For paper claims, Humana will:

- Provide claim receipt acknowledgment or provide electronic submitted claim status access to the provider or provider designee
- Pay or deny 90% of the clean claims within 30 days of receipt
- Pay or deny 99% of clean paper claims within 90 days of receipt

If applicable, providers paid on a capitation basis will be paid according to the time period specified in your provider agreement with Humana. Claims not billed within the required time frame will be considered waived.

Claims resubmission

For network providers

We will consider a claim for resubmission only if it is rebilled in its entirety and includes the resubmission code. The provider must include a letter outlining the reason for submission.

For non-network or non-participating providers

We will consider a claim resubmission within 365 days from the primary payers' remittance advice or explanation of benefits.

Claims reconsideration

Providers have 365 days from the date of remittance to resubmit a claim or the original payment will be considered full and final for the related claims. Providers must include:

- The nature of the request
- Member's name and date of birth
- Member identification number
- Service or admission date
- Treatment, service or procedure location
- Request-supporting documentation
- A copy of the claim
- A copy of the remittance advice on which the claim was denied or incorrectly paid

Providers must additionally include the following labels on claims when submitting for reconsideration:
ATTN: Claims Dept. – Reconsideration Claim
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Medicare and other primary payer sources

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

If the primary insurance carrier denies the claim as a non-covered service, the claim with the denial may be submitted to Humana for a coverage determination.

It is the provider's responsibility to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to members who have insurance in addition to the health plan. The primary carrier's EOB or remittance advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential for Humana to coordinate benefits.

If a service is a non-covered service or benefits have been exhausted from the primary carrier, the provider is required to get an updated letter from the primary carrier every January and July to submit with each claim. Claims submitted without the EOB for members where third-party insurance is available will be denied in most cases.

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

Overpayment/underpayment

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

Claims inquiries

Providers can check the status of claims by calling Provider Services at **800-787-3311** and selecting the Claims option

Prior authorization and referral procedures, including required forms

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

Protocols for submitting encounter data

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

Medical and case record standards

Standards shall support a clean claim, encounter data, program integrity (fraud) requirements, quality enhancement, HIPAA standards and medical necessity. The member case record includes member-specific documents

and documentation of all activities, interactions and contacts with the member, their representative, their case manager and any other provider(s) involved in the support and care of the member. The case management member file information is maintained by the plan in compliance with state and federal regulations for record retention. The plan manages this process through an approved policy and procedure and is available upon request.

Tools and information of value

NPI – National Provider Identifier standard

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

- Individuals or organizations that furnish atypical or non-traditional services that are only indirectly related to the provision of healthcare (examples include taxis, home modifications, home delivered meals and homemaker services)
- Individuals or businesses that only bill or receive payment for, but do not furnish, healthcare services or supplies (examples include billing services and re-pricers).

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

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

Phone: **800-465-3203** or **TTY 800-692-2326**

Email: customerservice@npienumerator.com

Mail: **NPI Enumerator**
P.O. Box 6059
Fargo, ND 58108-6059

Share NPI with Humana online through Availity.com. By the Code of Federal Regulations, the provider must submit all National Provider Identifiers (NPIs) to Humana.

Credentialing

To participate in Humana's network, providers must be enrolled via the state's IMPACT website. LTSS providers must, at a minimum, meet all regulatory guidelines.

Adopted and applicable provider attestations

The provider acknowledges and attests he or she will maintain compliance to attend and complete abuse, neglect and exploitation training. It is the provider's responsibility to use training materials approved in-advance per mandate, maintain necessary training documentation for employees that have contact with the health plan members and make this documentation available upon request to Humana and the applicable state agency.

Home and community-based services (HCBS) in supportive living facilities

In December 2012, the OIG published Home and Community-based Services in Assisted Living Facilities, OEI-09-08-00360. In the report, the OIG recommended that CMS issue guidance to state Medicaid programs emphasizing the need to comply with federal requirements for covering HCBS under the 1915(c) waiver. CMS also has published expectations regarding person-centered plans of care and to provide characteristics of non-home or community-based settings to ensure state compliance with the statutory provisions of Act section 1915(c).

What this means for residential HCBS providers such as supportive living facilities (SLF) is summarized as follows:

- A focus on quality of services provided
- An individualized person-centered care plan
- A community integration goal planning process
- The right to receive home and community-based services in a home-like environment

As a result, the health plan may take state-expected intervention or remediation steps. The following are some examples of intervention or remediation steps an MCO may implement upon discovery that an SLF is not maintaining a home-like environment:

- The MCO will work with SLF administrators and staff to correct the identified deficiencies within a state-mandated time frame.

- MCO will not refer members to the non-compliant SLF until outstanding deficiencies are resolved.
- The MCO will terminate network SLFs that consistently fail to exhibit home-like characteristics and do not resolve outstanding issues.
- As a last resort, the MCO may counsel a member who is not residing in a home-like environment that he/she will not be able to continue to receive HCBS waiver services in a noncompliant facility. If the member wishes to remain in the SLF, he/she may face plan disenrollment.
- If the health plan terminates a contract with an SLF and the member agrees to move to a different facility, the health plan would facilitate transferring the member to an SLF that meets the home-like environment requirements.

Residential facility providers agree to comply with the home-like environment and community integration language provided by the state. Such language may be included in your provider agreement. All providers must also comply with the applicable Resident Bill of Rights and attest to complying as part of the monitoring process.

Section III – Behavioral Health

Program description

Carelon/Humana partnership

Humana has partnered with Carelon Health Options LLC (Carelon) to manage the delivery of behavioral health services for its Medicare Medicaid Alignment Initiative (MMAI) Demonstration members in Illinois. The Demonstration is designed to provide members who are dually eligible for both Medicare and Medicaid with high quality, integrated care. Demonstration members are eligible to receive comprehensive assessments, care planning and coordination from Humana. For further details, please refer to the Humana section of this provider manual.

Carelon is a limited liability, managed behavioral healthcare company. Established in 1996, Carelon's mission is to collaborate with our health plan members and network providers to improve the delivery of behavioral healthcare for the members we serve. Carelon provides behavioral health management services to 42 million people through partnerships with more than 50 health plan partners in 50 states. Most often co-located at the physical location of our health plan partners, Carelon's in-sourced approach deploys local-market utilization managers, care managers and provider network professionals into Carelon's business area. This approach facilitates better coordination of care for members with physical, behavioral and social conditions and is designed to support a medical home model.

Quantifiable results prove that this approach improves the lives of individuals and their families and helps health plans to better integrate behavioral health with medical health.

Carelon/Humana Behavioral Health Program

The Humana behavioral health program provides members with access to a full continuum of behavioral health services through our network of Carelon network providers. The program's primary goal is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all health plan members receive timely access to clinically appropriate behavioral healthcare services, Humana and Carelon believe that quality clinical services can achieve improved outcomes for our members.

Network Operations Department

In coordination with Humana's Provider Relations Department, Carelon's Network Operations Department is responsible for the procurement and administrative management of Carelon's behavioral health provider network. Carelon's role includes contracting and provider relations functions for all behavioral health contracts. Representatives are easily reached by email at SoutheastServiceCenterPR@beaconhealthoptions.com, or by phone between 8:30 a.m. – 6 p.m. Eastern time, Monday – Thursday, and 8:30 a.m. – 5 p.m. Fridays at **855-371-9234** for routine matters; clinical staff be reached there 24 hours a day, seven days a week for authorization requests.

Contracting and maintaining network participation

A Carelon network provider is an individual practitioner, private group practice, licensed outpatient agency, or facility that has been credentialed by the state's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system signed a Provider Services Agreement (PSA) with Carelon and Humana. Network providers agree to provide behavioral health and/or substance use covered services to members, to accept reimbursement according to the rates set forth in each provider's PSA and to adhere to all other terms in the PSA (including this provider manual). Carelon network providers who maintain approved status remain active network providers unless the PSA is terminated in accordance with the terms and conditions set forth therein. In cases where a network provider is terminated, such providers may notify the member of their termination. Carelon will also always notify members when their provider has been terminated and work to transition members to another Network provider to avoid unnecessary disruption of care.

About this section

This behavioral health provider policy and procedure section is a legal document incorporated by reference as part of each provider's Carelon provider services agreement or Humana Provider Participation Agreement The manual serves as an administrative guide outlining Carelon's policies and procedures governing network participation, service provision, claims submission, quality management and improvement requirements, in Chapters 1–3. Detailed information regarding clinical processes, including authorizations, utilization review, care management, reconsiderations and provider appeals are found in Chapters 4 and 5. Chapter 6 covers billing transactions. Carelon's level-of-care criteria (LOCC) are accessible through eServices or by calling Carelon at **855-371-9234**. Additional information can be found on the Carelon provider portal at carelonbehavioralhealth.com providers.

The manual is posted on both Humana and Carelon's websites and on eServices, Carelon's provider portal; only the version on eServices includes Carelon's LOCC. Providers also may request a printed copy of the manual by calling **855-371-9234**

Manual updates as permitted by the provider services agreement will be posted on Humana and Carelon websites and notification may also be sent by postal mail and/or email. Carelon provides network provider notification at least 60 days prior to the effective date of any policy or procedural change impacting network providers, such as payment modification or covered services. Carelon provides 60 days' notice unless the change is mandated sooner by state or federal requirements.

Carelon transactions and communications

Carelon's website carelonbehavioralhealth.com contains answers to frequently asked questions, Carelon's clinical practice guidelines, clinical articles, links to numerous clinical resources and important news for network providers. As described below, eServices and EDI also are accessed through the website.

Electronic media

To streamline network providers' business interactions with Carelon, we offer three provider tools – eServices, Interactive Voice Recognition (IVR) and Electronic Data Interchange (EDI).

eServices

Through eServices, Carelon's secure web portal, all provider transactions are supported, which saves time, postage expense, billing fees and reduces paper waste. Access to eServices is free to Humana- contracted Carelon network providers and can be found at carelonbehavioralhealth.com, 24 hours a day, seven days a week.

Some features include:

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

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

Click here to register for eServices

Please have your practice or organization NPI and tax identification numbers available. The first user from a provider organization or practice will be asked to submit, via fax, a signed copy of the eServices Terms of Use. The user will be designated as the account administrator unless/until another designee is identified by the provider organization. Carelon activates the account administrator's account as soon as the terms of use are received.

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

NOTE: The account administrator should be in a management role, with appropriate authority to manage other users in the practice or organization. The provider may reassign the account administrator at any time by emailing SoutheastServiceCenterPR@beaconhealthoptions.com.

Interactive voice recognition

Interactive voice recognition (IVR) is available to providers as an alternative to eServices. It provides accurate, up-to-date information by telephone, and is available for selected transactions at **855-371-9234**.

In order to maintain compliance with HIPAA and all other federal and state confidentiality and privacy requirements, network providers must have their practice or organizational Tax Identification Number (TIN), National Provider Identifier (NPI), as well as member's full name, plan ID and date of birth, when verifying eligibility through eServices and through Carelon's IVR.

Electronic data interchange

Electronic data interchange (EDI) is available for claim

submission and eligibility verification directly by providers to Carelon or via an intermediary. For information about testing and EDI setup, download Carelon's 837 and 835 companion guides.

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

To set up an EDI connection, view the companion guide located on Carelon's provider portal carelonbehavioralhealth.com/providers, then contact e-support.services@beaconhealthoptions.com. You may submit any technical- or business-related questions to the same email address. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Emdeon, use Carelon's Emdeon Payer ID 43324 and Carelon's health plan 054.

TABLE 3-1 ELECTRONIC TRANSACTIONS AVAILABILITY

Transaction/capability	eService	IVR	EDI
Verify member eligibility, benefits and copayment	Yes	Yes	
Check number of visits available	Yes	Yes	
Submit authorization requests	Yes		
View authorization status	Yes	Yes	
Update practice information	Yes		
Submit claims	Yes		Yes (HIPAA 837)
Upload EDI claims to Carelon and view EDI upload history	Yes		Yes (HIPAA 837)
View claims status	Yes	Yes	
Print claims reports and graphs	Yes		
Download Electronic Remittance Advice	Yes		
EDI acknowledgment and submission reports	Yes		Yes (HIPAA 837)
Pend authorization requests for internal approval	Yes		
Access Carelon's level-of-care criteria and provider manual	Yes		

Email

Carelon encourages providers to communicate with Carelon by email addressed to SoutheastServiceCenterPR@beaconhealthoptions.com. Throughout the year, Carelon sends network providers alerts related to regulatory requirements, protocol changes and helpful reminders regarding claim submission, etc. To receive these notices in the most efficient manner, we strongly encourage you to enter and update email addresses and other key contact information for your practice through eServices.

Communication of member information

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

Unless in certain circumstances, it is a HIPAA violation to include any patient-identifying information or protected health information.

Access standards

Humana members may access behavioral health services 24 hours-a-day, seven days-a-week by contacting Humana's member services line **855-371-9234**. The main Humana line includes an option for connecting directly to Carelon Health Options member services for emergencies or authorization requests for acute levels of care. For most members, referrals are not required to access behavioral health services. Authorization and referrals are never required for emergency services.

Humana and Carelon adhere to state and National Committee for Quality Assurance (NCQA) guidelines for access standards for member appointments.

TABLE 3-2 APPOINTMENT STANDARDS AND AVAILABILITY	
Type of care	**Appointment availability**
Emergency care with crisis stabilization	Immediate Access
Urgent care	Immediate Access
Post discharge from acute hospitalization	Within seven days of discharge
Other routine referrals or appointments	Within 30 days

Access standards for Humana's behavioral health network are established to ensure that members have service access within 30 miles or 30 minutes from their address within urban areas, and 60 miles or 60 minutes of their address within rural areas.

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

TABLE 3-3 SERVICE AVAILABILITY AND AFTER-HOURS ACCESSIBILITY	
Service availability	**Hours of operation (local time):**
On-call	• 24-hour on-call services for all members in treatment • Ensure that all members in treatment know how to contact the treating or covering provider after hours and during provider vacations.
Crisis intervention	• Services must be available 24 hours a day, seven days per week • Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours • After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team or hospital
Outpatient services	Outpatient providers should have services available Monday through Friday from 9 a.m. to 5 p.m. at a minimum; evening and/or weekend hours also should be available at least two days per week.
Interpreter services	Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.
Cultural competency	Providers must ensure that members have access to medical interpreters, signers and TTY services to facilitate communication when necessary and ensure that clinicians and agencies are sensitive to the diverse needs of Humana members.

Medical homes

All providers are encouraged to consider an affiliation with a medical home. Some providers may serve as a medical home, which is designed to provide fully integrated member care. For further information on the medical home model, please contact Carelon at **855-371-9234**.

Members with disabilities

Provider locations must be accessible for Humana members with disabilities. As necessary to serve members, provider locations where members receive services must be compliant with the Americans with Disabilities Act (ADA). Providers may be required to attest that their facilities are ADA compliant. Providers are required to meet these standards and notify Carelon if temporarily or permanently unable to do so. If a provider fails to provide services within these access standards, notice is sent out within one business day informing the member and provider that the waiting time access standard was not met.

Provider credentialing and recredentialing

Carelon conducts a rigorous credentialing process for network providers based on CMS and National Committee for Quality Assurance (NCQA) guidelines. All providers must be approved for credentialing by Carelon to participate in its behavioral health services network, and must comply with recredentialing standards by submitting requested information. Private, individual and group practice clinicians are individually credentialed, while facilities are credentialed as organizations. To request credentialing information and an application(s), please email SoutheastServiceCenterPR@beaconhealthoptions.com.

Provider training

Please see Section I of this manual.

Member billing prohibitions

Health plan members may not be billed for any covered service or any balance after reimbursement by Carelon, except for any applicable copayment. Further, providers may not charge MMAI members for any services not deemed medically necessary upon clinical review, or which are administratively denied. It is the provider's responsibility to check benefits prior to beginning treatment for any MMAI member and to follow the procedures set forth in this manual.

Out-of-network providers

Out-of-network behavioral health benefits are limited to:

- Covered services that are unavailable in the existing Humana or Carelon network
- Emergency services and transition services for members currently in treatment with an out-of-network provider who is in the process of joining the network, or otherwise required by Humana's contract with the state.

Out-of-network providers must complete a single case agreement (SCA) with Carelon. Out-of-network providers may provide one evaluation visit for Humana members without an authorization upon completion and return of the signed SCA. After the expiration of existing authorizations, the provided services must be authorized by Carelon. Outpatient device authorization requests can be obtained by calling **855-371-9234**. If this process is not followed, Carelon may administratively deny the services and the out-of-network provider must hold the member harmless.

Out-of-network providers who wish to join Carelon's network should contact our network department by calling **855-371-9234**.

Provider database

Carelon and Humana maintain a provider-reported database of provider information. This database can be found on Carelon's website carelonbehavioralhealth.com. A hard copy can be requested through **855-371-9234**. Database accuracy is critical to essential functions such as:

- Network monitoring to ensure member access to a full continuum of services across the entire geographic service area
- Regulatory reporting requirements
- Member referrals
- Network monitoring to ensure compliance with quality and performance standards including appointment access standards

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

TABLE 3-4 REQUIRED NOTIFICATIONS

Type of Information
General practice information
Change in address or telephone number of any service
Addition or departure of any professional staff
Change in linguistic capability, specialty or program
Discontinuation of any covered service listed in the Behavioral Health Services Agreement
Change in licensure or accreditation of provider or any of its professional staff
Changes in hours of operation
Cessation of new member acceptance
Limited hour and setting availability
Member treatment restrictions
Temporary or permanent inability to meet Carelon appointment access standards
Change in designated account administrator for the provider's eServices accounts
Merger, change in ownership, or change of tax identification number
When adding a site, service or program not previously included in the Behavioral Health Services Agreement, please remember to specify the site location and its capabilities.

Adding sites, services and programs

Your contract with Carelon is specific to the sites, rates and services originally specified in your provider service agreement.

To add a site, service or program not previously included in your PSA, notify Carelon of the new location and any service or program capabilities. Carelon and Humana will coordinate to determine whether the site, service or program meets identified geographic, cultural, linguistic and/or specialty network needs.

Members, benefits and member-related policies

Covered services

Humana covers behavioral health and substance use services via Carelon that are provided to members located in the state of Illinois. Under the health plan, the following levels of care are covered, provided that such services are:

- Medically necessary
- Delivered by contracted network providers (or as part of a member's transition plan if provider is not in network)

The authorization procedures outlined in this manual should be followed. Please refer to your contract with Carelon for specific information about procedure and revenue codes and rates for these services:

- Outpatient behavioral health and substance use services
- Community-based (Rule 132) mental health services
- Partial hospitalization
- Intensive outpatient services
- Division on alcohol and substance use services
- Inpatient hospitalization
- Crisis stabilization and observation
- ER services

Plan members may access behavioral health services by self-referring to a network provider, calling Carelon, or by referral through acute or ER encounters. Members also may access behavioral health services via PCP referral. Some behavioral health and substance use services for Demonstration members may require referral from the member's PCP. Please contact Carelon for more information about referral requirements. Network providers are expected to coordinate care with a member's PCP and other treating providers whenever possible.

Additional benefit information

- Benefits do not include payment for behavioral healthcare services that are not medically necessary.
- Neither Carelon nor Humana is responsible for the costs of investigational drugs or devices, or non-healthcare services such as managing research or the costs of collecting data that is useful for the research project, but not medically necessary for the member's care
- Authorization may be required for all services
- Opioid maintenance is not a covered benefit (with the exception of emergency services)

Member rights and responsibilities

Member rights

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

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

Right to submit Carelon complaints or concerns

Members and their legal guardians have the right to file a complaint or grievance with Carelon or Humana regarding any of the following:

- The quality of member care delivered by a Carelon network provider
- The Carelon utilization review process
- The Carelon network of services

Member grievances will be handled directly by Humana. The procedure for filing a complaint or grievance is described in Grievance and appeals system portion of this manual.

Right to contact Carelon ombudsperson

Members have the right to contact Carelon's Office of the Ombudsperson to obtain a copy of Carelon's Member Rights and Responsibilities statement. The Carelon ombudsperson may be reached at **855-371-9234** or by **TTY** at **866-727-9441**.

Right to make recommendations about member rights and responsibilities

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

Posting member rights and responsibilities

All network providers must display, in a highly visible and prominent place, a statement of member rights and responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Carelon's statement or a comparable statement consistent with the provider's state license requirements.

Informing members of their rights and responsibilities

Providers are responsible for informing members of their rights and respecting those rights. In addition to a posted statement of member rights, providers also are required to:

- Distribute and review a written copy of member rights and responsibilities at the initiation of every new treatment episode and include signed documentation of this review in the member's medical record
- Inform members that Carelon does not restrict the ability of network providers to communicate openly with plan members regarding all treatment options available to them – including medication treatment – regardless of benefit coverage limitations
- Inform members that Carelon offers no financial incentives to its network provider community for limiting, denying, or not delivering medically necessary treatment to plan members
- Inform members that clinicians working at Carelon receive no financial incentives to limit or deny any medically necessary care

Non-discrimination policy and regulations

Providers agree to treat plan members without discrimination. Providers may not refuse to accept and treat a health plan member on the basis of:

- Income
- Gender
- Creed
- National origin
- Marital status
- Claims experience
- Pre-existing conditions
- Physical or mental condition
- Sexual orientation
- Color
- English proficiency
- Veteran's status
- Duration of coverage
- Health status
- Age
- Religion
- Physical or mental disability
- Ancestry
- Occupation
- Race/ethnicity
- Ultimate payer of services

In the event that a provider cannot provide appropriate member services, he or she should direct the member to call Carelon for assistance in locating needed services.

Network providers may not close their practice to health plan members unless it is closed to all patients. The exception to this rule is that a provider may decline to treat a member for whom he or she does not have the capability or capacity to provide appropriate services. In that case, either the member or the provider should contact Carelon for assistance in locating appropriate services.

State and federal laws prohibit discrimination against any individual who receives federal, state or local public assistance, including medical assistance or unemployment compensation, solely because that person receives assistance.

It is our joint goal to ensure that all members receiving medically necessary behavioral healthcare that is accessible, respectful and maintains the dignity of the member.

Confidentiality of member information

All providers are expected to comply with federal, state and local laws regarding access to member information. With the enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), members are not required to give consent for the release of information regarding treatment, payment and healthcare operations when enrolling in health insurance, starting treatment or making payment. Healthcare operations involve a number of different activities, including, but not limited to:

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

Member consent

At every member intake and treatment admission, providers should explain the purpose and benefits of communication with the member's PCP and other relevant providers. The behavioral health clinician should then ask

the member to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional member status information.
A sample form is available at carelonbehavioralhealth.com/providers (see Provider Tools web page), or providers may use their own form; the form must allow the member to limit the scope of shared information.

Members can elect to refuse to consent to the release of any information, treatment, payment and operations, except as specified in the previous section. Whether providing or declining consent, the member's signature is required and should be included in the medical record.

If a member refuses to release information, the providers should clearly document the reason for refusal in the narrative section on the form. In addition, the provider should advise the member that authorization refusal for release of information for payment purposes, he or she will be held personally responsible for payment outside the health plan.

Confidentiality of HIV-related information

At every treatment intake and admission, providers should explain the purpose and benefits of Carelon's collaboration with the plan to provide comprehensive health services to members with health conditions that are serious, complex, and involve both medical and behavioral health factors. Carelon coordinates care with health plan medical and disease management programs and accepts health plan referrals for behavioral healthcare management. Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is available directly from the health plan. Carelon will assist behavioral health providers or members interested in obtaining any of this information by referring them to the health plan's care management department.

Carelon limits access to all health-related information – including HIV-related information and medical records — to staff trained in confidentiality and the proper management of patient information. Care management protocols require Carelon to provide any health plan member with assessment and referral to an appropriate treatment source. It is Carelon's policy to follow federal and state information laws and guidelines concerning the confidentiality of HIV-related information.

Humana health plan member eligibility

Possession of a health plan member identification card does not guarantee a member benefit eligibility. Providers are strongly encouraged to frequently check member eligibility.

The following resources are available to assist in eligibility verification:

TABLE 3-5 MEMBER ELIGIBILITY VERIFICATION TOOLS

Online	Via telephone
Carelon eServices	**855-371-9234** - Carelon's integrated voice recognition (IVR)

Providers also may use Availity's provider portal online to check member eligibility, or call Provider Services.

Provider Services: Provider Portal

Sign in to carelonbehavioralhealth.com and select providers from the menu options.

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

Using our secure provider portal, you can check Humana member eligibility for up to 24 months after the date of service using any of the following:

- Member name and date of birth
- Case number
- Medicaid (MMIS) number
- Humana member ID number

Multiple member ID numbers may be searched in a single request.

Call our automated member eligibility verification system at **855-371-9234** from any touch-tone phone and follow the appropriate menu options to reach our automated member-eligibility verification system. The automated system, available 24 hours a day, will prompt you to enter the member ID number and the month of service to check eligibility.

To maintain HIPAA compliance and all other federal and state confidentiality or privacy requirements, providers must supply their practice or organizational TIN, NPI, the member's full name, plan ID and date of birth when verifying eligibility through eServices and Carelon's IVR. The Carelon Clinical Department also may assist the provider in verifying member enrollment in the Humana health plan when authorizing services.

In accordance with the Privacy Act, Carelon requires the provider be prepared to provide specific identifying information (provider ID number, member's full name and date of birth) during the process to avoid inadvertent disclosure of sensitive health information.

NOTE: Member eligibility information on eServices and through IVR is updated nightly. Eligibility information

obtained by phone is accurate when provided. Carelon cannot anticipate, and is not responsible for, retroactive changes or disenrollments reported at a later date. Providers should frequently check eligibility.

Quality management and improvement (QM and I)

Program description

Carelon administers a Quality Management and Improvement (QM and I) Program which strives to continually monitor and improve the effectiveness of behavioral health services delivered to members. Carelon's QM and I Program integrates the principles of Continuous Quality Improvement (CQI) throughout its organization and the provider network.

Program principles

- Continually evaluate the delivered effectiveness of services provided to health plan members
- Identify areas for targeted improvements
- Develop QI action plans to address improvement needs
- Continually monitor the effectiveness of changes implemented over time

Program goals and objectives

- Improve member healthcare status
- Enhance continuity and coordination among behavioral healthcare providers and between behavioral healthcare and physical healthcare providers
- Establish effective and cost-efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders
- Ensure members receive timely and satisfactory service from Carelon and network providers
- Maintain positive and collaborative working relationships with network practitioners and ensure provider satisfaction with Carelon services
- Responsibly contain healthcare costs.

Provider role

Humana and Carelon employ a collaborative model of continuous QM and I, in which provider and member participation is actively sought and encouraged. Humana and Carelon require each provider to develop his or her own internal QM and I Program to continually assess quality of care, access to care and compliance with medical necessity criteria.

All providers are expected to provide members with disease-specific information and preventive care information that can assist the member understanding illness and support recovery. Member education should be person-centered, recovery-focused and promote compliance with treatment directives and encourage self-directed care.

To participate in Carelon's Provider Advisory Council, email SoutheastServiceCenterPR@beaconhealthoptions.com. Members interested in participation with Carelon's Member Advisory Council should contact the member services department.

Quality monitoring

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

- Site visits
- Treatment record reviews
- Satisfaction surveys
- Internal monitoring of timeliness and accuracy of claims payment, provider compliance with performance standards including, but not limited to:
  - Timeliness of ambulatory follow-up after behavioral health hospitalization
  - Discharge planning activities
  - Communication with member PCPs, behavioral health provider peers, government and community agencies
  - Tracking of adverse incidents, complaints, grievances and appeals
  - Other quality improvement activities

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

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

Treatment records

Treatment record reviews

Carelon reviews member charts and utilizes data generated to monitor and measure provider performance in relation to Carelon's treatment record standards and specific quality initiatives established each year. The following

elements are evaluated (in addition to any state-specific regulatory requirements) regarding chart review for special services such as Rule 132 services.

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD
- Continuity and coordination with primary care and other providers
- Explanation of member rights and responsibilities
- Inclusion of all applicable state-required medical record elements as identified in administrative regulations, service manuals and NCQA
- Allergies and adverse reactions, medications, physical exam and evidence of advance directives

Humana and Carelon may conduct on-site chart reviews at a provider facility or request that specified sections of a member's medical record be sent to Carelon. Any provider questions regarding Carelon's access to the plan member information should be directed to Carelon Privacy through **855-371-9234**.

HIPAA regulations permit providers to disclose information without patient authorization to provide oversight of the healthcare system, including quality assurance activities. Carelon chart reviews fall within this area of allowable disclosure.

Treatment record standards

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

TABLE 3-6 TREATMENT RECORDS DOCUMENTATION REQUIREMENTS

Documentation	• Is there documentation that the member received a copy of his or her rights? • Are medication allergies & adverse reactions prominently noted in the record? If the member has no known allergies or adverse reactions, are these noted? • Is past medical history easily identified? If no significant medical history, is this noted? • Is there documentation that the member received a copy of the HIPAA notice of privacy practices?
Continuity and Coordination - Outpatient to Outpatient	• Is there evidence in the chart that at least one Release of Information, Authorization, or Consent was obtained to speak with at least one other Outpatient [OP] mental health or OP substance abuse treatment provider if required for specially protected information? • Is there evidence that the OP treatment provider contacted other OP BH Provider after initial assessment/evaluations for collaboration? • Is there evidence that the OP treatment provider had ongoing contact with other BH Provider at other significant points in treatment e.g. medication initiated, discontinued, or significantly altered; significant changes in diagnosis or clinical status and at termination of treatment? • Is there evidence that the OP treatment provider contacted, collaborated, received clinical information from or communicated in any way with any state agencies or schools, community outlets, etc.? • Timeliness: Communication within 30 days of initial assessment

Continuity and Coordination - PCP to Outpatient	• Is there evidence in the chart that a Release of Information was obtained to communicate with the PCP if required for specially protected information? • Member refuses due to active symptoms. • Member refuses due to expressed concern over privacy. • Guardian does not want information shared with PCP. • Member will not state a reason. Example: legal issues, member does not want medical records to be released to another party • Is there evidence that the OP treatment provider contacted and collaborated after initial assessment/evaluation? • Is there evidence that the OP treatment provider had ongoing contact with PCP at other significant points in treatment e.g. medication initiated, discontinued, or significantly altered; significant changes in diagnosis or clinical status and at termination of treatment? • Is there evidence of bi-directional communication
Evaluation of Treating Provider Communication (BH:PCP)	• Timeliness: Communication within 30 days of initial assessment
Clinical Practice Guidelines	• Adult Suicide Risk CPG: Was the member asked about thoughts of suicide or self-harm? (18+) • Adult Suicide Risk CPG: Was a standardized suicide risk screening or assessment tool used? (18+) • Adult Suicide Risk CPG: If yes to 2., what tool was used? Use drop down to identify tool, or mark NA (18+) • Adult Suicide Risk CPG: Where risk was identified, was at least brief safety planning intervention done to develop a plan to recognize suicidal thoughts and manage them safely? (18+) • Adult Psychiatric Evaluation CPG: Is there documentation of a substance use assessment? (18+) • Adult Psychiatric Evaluation CPG: Is there documentation of a cultural and/or linguistic assessment? (18+) • Adult Psychiatric Evaluation CPG: Is there documentation of a medical assessment? (18+) • ADHD CPG: Is there documentation that the member meets the DSM-5 criteria, including documentation of symptoms and impairment in more than 1 major setting (i.e., social, academic, or occupational)? • ADHD CPG: Is there documentation that when assessing a member's diagnosis, differential diagnoses or alternative causes were ruled out?
Targeted Clinical Review	• Is the DSM or ICD diagnosis consistent with presenting problems, history, mental status exam and treatment plan? • Does the treatment plan include objective and measurable goals? • Does the treatment plan include short-term timeframes for goal/objective attainment or problem resolution? • Is utilization appropriate for diagnosis and treatment plan? • Are progress notes goal directed & focused on treatment objectives?
Telehealth Member Safety (APPLICABLE TO ALL CHARTS IF TELEHEALTH MODALITY)	• Did the provider document member's written or oral consent to receive services via Telehealth? • Did Provider document that session was conducted via video or phone? • Did Provider document member's physical location at beginning of session? • If there was a technical difficulty did provider document alternate communication and how session was continued or rescheduled?

In addition to the MMAI Demonstration member requirements above, providers are required to capture the following information in the member's medical record:

- Birthdate
- A summary of significant surgical procedures
- Description of chief complaint or visit purpose, the objective diagnosis, medical findings and the provider's impression
- Identification of any studies ordered
- Identification of any prescribed and administered therapies
- Disposition, recommendations, member instructions and evidence of follow-up and service outcome
- Immunization history
- Summaries of all emergency services and care and hospital discharges that include appropriate follow-up
- Documentation of member referral services and medical records
- All provider services (family planning services, preventive services, etc.)
- Primary language spoken by the member and any member translation needs
- Identify members needing communication assistance in the delivery of healthcare services

Advance directives

Carelon practices an integrated approach to advance directives between behavioral health and medical care providers. As per federal law (Patient Self-determination Act, 42 U.S.C.A. § 1396a[w] [West 1996]), providers participating in the Medicare and Medicaid programs are required to furnish patients with information on advance directives. The information is to be given to patients upon admission to a facility or when provision of care begins.

Documentation that the member was provided with this information must be noted in the member's treatment record, and must specify whether the member has executed an advance directive. The member's advance directive decision should be periodically reviewed between the provider, member, and/or the member's legal guardian (if applicable). This should be closely coordinated with the care manager around significant changes in the member's condition, diagnosis, and/or level of care.

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

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

Performance standards and measures

To ensure a consistent level-of-care within the provider network, and a consistent framework for evaluating the effectiveness of care, Carelon has developed specific provider performance standards and measures. Behavioral health providers are expected to adhere to the performance standards for each level of provided member care, which includes, but is not limited to:

- Communication with PCPs and other providers treating shared members
- Availability of routine, urgent and emergent appointments (see Table 3-2)

Practice guidelines

Carelon and Humana promote delivery of behavioral health treatment based on scientifically proven methods. We have researched and adopted evidence-based guidelines for treating the most prevalent behavioral health diagnoses, including guidelines for ADHD and substance use disorders and have posted links to these guidelines on our website.

We strongly encourage providers to use these guidelines and to consider these guidelines whenever they may promote positive outcomes for clients. Carelon monitors provider utilization of guidelines through the use of claim, pharmacy and utilization data.

Carelon welcomes provider comments about the relevance and utility of its guidelines, any improved client outcomes noted as a result of guideline application and about provider experience with any other guidelines. To provide feedback or request paper copies of the Carelon practice guidelines, contact us.

Outcome measurement

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

Carelon receives aggregate data by provider including demographic information and clinical and functional status without member-specific clinical information.

Communication between outpatient behavioral health providers, PCPs and other providers

Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient

behavioral health providers if applicable, as follows:

- Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first
- Updates at least quarterly during the course of treatment
- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within two weeks; behavioral health providers may use Carelon's Authorization for Behavioral Health Provider and PCP to share information. The Behavioral Health-PCP Communication Form is available for initial communication and subsequent updates.

Carelon's provider portal at carelonbehavioralhealth.com/providers or their own form that includes the following information:

- Presenting problem/reason for admission
- Date of admission
- Admitting diagnosis
- Preliminary treatment plan
- Currently prescribed medications
- Proposed discharge plan
- Behavioral health provider contact name and telephone number

Request for PCP response by fax or mail within three business days of the request to include the following health information:

- Status of immunizations
- Date of last visit
- Dates and reasons for any and all hospitalizations
- Ongoing medical illness
- Current medications
- Adverse medication reactions, including sensitivity and allergies
- History of psychopharmacological trials
- Any other medically relevant information.

Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.

Communication between inpatient/diversionary providers and PCPs, other outpatient providers

With the member's informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers also must alert the PCP 24 hours prior to a pending discharge and must fax or mail the following member information to the PCP post-discharge:

- Date of discharge
- Diagnosis
- Medications
- Discharge plan
- Aftercare services for each type, including:
  - Name of provider
  - Date of first appointment
  - Recommended frequency of appointments
  - Treatment plan

Inpatient and diversionary providers should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one.

Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Carelon's member record.

State-specific Demonstration model-of-care requirements

Providers must follow the procedures below as per state guidelines:

- Facilitate member referral to specialists or specialty care, behavioral healthcare services, health education classes and community resource agencies, when appropriate
- Integrate medical screening with basic primary care services provided to demonstration members
- Provide screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders
- Deliver evidence-based behavioral health treatment and establish protocols for referral to behavioral health specialty providers
- Ensure member confidentiality of medical and behavioral health and personal information as required by state and federal laws

Member transfer between behavioral healthcare providers

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

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

Follow-up after behavioral health hospitalization

All inpatient providers are required to coordinate after-care appointments with community based mental health providers prior to member discharge. Carelon's UM and care management staff can assist providers in determining a member's existing treatment engagement with behavioral health provider and assist with referrals to ensure that members released from in-patient levels of care are scheduled for follow-up appointments within seven days of discharge. Providers are responsible for seeing members within that time frame and for reaching out to members who miss their appointments within 24 hours after the appointment is missed.

Carelon's care managers and aftercare coordinators assist by sending member reminders to members; working to remove barriers that may prevent a member from keeping his or her discharge appointment, and coordinating with treating providers.

Network providers are expected to aid in this process as much as possible to ensure that members have the support needed to maintain community placement and prevent unnecessary readmissions.

Reportable incidents and events

Humana Illinois Duals Program require Carelon network practitioners and providers to report all potential Quality of Care and critical incidents on the day of the incident to Carelon involving a covered individual by calling **855-371-9234**.

TABLE 3-7 REPORTABLE INCIDENTS/EVENTS

Potential Quality of Care (PQOC) Concern: Any clinical or system variance warranting further review and investigation to determine the provider's contribution to a quality issue or deviation from the standard of care or service. PQOCs are initial reports of a Serious Reportable Event (SRE) or Trending Event (TE) prior to the conclusion of an investigation.

Humana Illinois Duals Program require Carelon network practitioners and providers to report all adverse and critical incidents on the day of the incident to Carelon involving a covered individual that include, but are not limited to, the following: See Illinois Critical Incidents – Appendix L, M, N of Illinois Contract

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TABLE 3-7 REPORTABLE INCIDENTS/EVENTS – continued

Member safety is paramount, contact 911, local authorities or Emergency Medical Services if member's health and safety is at immediate risk

1. Death, customer. Does not include natural deaths. Report death that is unusual in nature, particularly if death arose to neglect or abuse.
2. Death, Other Parties (Events that result in significant event for customer (i.e. death of caregiver while giving customer a bath, leaving a customer stranded. Does not include family members if no harm to customer)
3. Physical Abuse of customer (non-accidental use of force that results in bodily injury, pain or impairment. Includes but not limited to being slapped, burned, cut, bruised or improperly physically restrained)
4. Verbal/Emotional abuse of customer
5. Sexual abuse of customer
6. Problematic possession or use of weapon by a customer, particular in staff's presence. Any perceived threat should also be reported.
7. Customer displays physical aggressive behavior, particularly if violence results in harm or injury to the provider
8. Property Damage by customer of $50 or more to provider property
9. Suicide attempt by customer and/or Suicide ideation/threat by customer
10. Suspected alcohol or substance abuse by customer
11. Seclusion of a customer (placing a customer in a locked or barricaded area that prevents contact with others)
12. Exploitation of Customer (can include misappropriation of assets or resources of the victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law.)
13. Neglect of customer (withholding necessities of life including, but not limited to food, clothing, shelter or medical care.)
14. Sexual Harassment by provider, sexual Harassment by customer, and/or sexual problematic behavior of the customer or provider
15. Sexual Harassment by customer / Sexual Problematic Behavior by customer or provider
16. Significant Medical Event of Provider that has the potential to impact upon a customer's care.
17. Significant Medical Event of Customer - this includes a recent event or new diagnosis that has the potential to impact on the customer's health or safety. Also included are unplanned hospitalizations or errors in medication administration by provider.
18. Customer arrested, charged with or convicted of a crime - if this could lead to risk or potential risk of customer's health
19. Provider arrested, charged with or convicted of a crime – if this could lead to risk or potential risk of customer's health
20. Self-Neglect: Individual neglects to attend their basic needs, such as personal hygiene, appropriate clothing, feeding or tending appropriately to medical conditions.
21. Customer is Missing: customer is missing or whereabouts are unknown for provision of services
22. Unauthorized Restraint of a customer
23. Media involvement/media inquiry - any inquiry or report/article from a media source concerning any aspect of a customer's case should be reported via an incident report. Additionally, all media requests will be forwarded to the DHS Office of Communications for response.
24. Threats made against DRS/HSP Staff - Threats and/or intimidation manifested in electronic, written, verbal, physical acts of violence, or other inappropriate behavior

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TABLE 3-7 REPORTABLE INCIDENTS/EVENTS – continued

25. Falsification of credentials or medical records or official papers for the expressed interest of personal gain, monetary or otherwise
26. Report against DHS/HSP employee - Deliberate and unacceptable behavior initiated by an employee of DRS against a customer or provider in HSP.
27. Bribery or attempted bribery of a HSP Employee - Money or favor given to an HSP employee in exchange to influence the judgment or conduct of a person in a position of authority.
28. Fire / Natural Disaster - Any event or force of nature that has catastrophic consequences, such as flooding, tornados, or fires.
29. In addition to above, Illinois Department on Aging Elder Abuse and Neglect Program (mistreatment of customers 60 years of age or older who live in a community), also include reporting for Elderly: Physical Abuse, Sexual Abuse, Emotional Abuse, Confinement, Passive Neglect, Willful Deprivation, Financial Exploitation
30. In addition to above, Illinois Department of Healthcare and Family Services Incident Reporting for Supportive Living Facilities, also include report for: Abuse or suspected abuse, allegations of theft when resident involves local law enforcement, elopement of residents/missing residents, any crime that occurs on facility property, fire alarm activation that results in on-site response by local fire department personnel, physical injury suffered by residents during a mechanical failure or force of nature, loss of electrical power in excess of an hour, evacuation of residents for any reason.

Reporting	• Carelon's Clinical Department is available 24 hours a day • Providers must call, regardless of the hour, to report such incidents **855-371-9234**
Method	• Providers should direct all such reports to their Carelon clinical manager or UR clinician by phone who are required to fax a copy of the Potential Quality of Care (PQOC) Concern form to Carelon's ombudsperson at **888-643-4197** • Incident and event reports should not be emailed unless the provider is using a secure messaging system
Prepare to provide the following:	Providers should be prepared to present: • All relevant information related to the nature of the incident • The parties involved (names and telephone numbers) • The member's current condition

Care management

Care coordination

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

The description below is designed to provide a broad overview of Humana's care management program. Many members may already receive community-based case management through the community mental health center network in Illinois. Humana and Carelon will engage existing case managers whenever possible to ensure continuity of care, avoid unnecessary disruption in services and multiple contacts.

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

- Participation in ICT care conferences via phone, through exchange of written communications and in-person
- Participation in inbound and outbound communications to foster care coordination
- Promote HEDIS® and NCQA quality measures
- Provide all medical record documentation and information as requested to support Humana's fulfillment of state and federal regulatory and accreditation obligations, (e.g., HEDIS)

Provider's role and responsibility in care coordination, care transitions, comprehensive medication reviews and preventive screenings:

- Assure that members are informed of specific healthcare needs requiring follow-up and receive self-care training that includes medication adherence and other measures to promote health.
- Ensure the member receives necessary and appropriate specialty, ancillary, emergency and hospital care, and is provided the necessary referrals and communication to specialists, hospitalists, SNFists and other providers needed to assist consultation and treatment recommendation, equipment and/or member services
- Provide coordination of care for members who are homebound or have significant mobility limitations to ensure access to care through home visits by nurse practitioners or physicians.
- Track and document appointments, clinical treatment plans and member care received from referred to specialists, other healthcare providers or agencies to ensure continuity of care
- Obtain authorizations and notify Humana for any out-of-network services when an in-network provider of the specialty in question is not available in the geographical area
- Work with Humana's care coordination team to arrange for a member to receive a second opinion from a qualified in-network healthcare professional or arrange for the member to obtain one outside the network, if a qualified in-network provider is unavailable
- Initiate or assist with the discharge or transfer of members from an inpatient facility to the most medically appropriate level-of-care facility or back to the member's home or permanent place of domicile. Consider the availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities
- Support, participate in, and communicate with the ICT, in person and/or in writing, in development and implementation of an individualized plan of care to facilitate effective care coordination
- Provide timely access to medical records or information for quality management and other purposes, including audits, reviews of complaints or appeals, HEDIS, and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate
- Follow the preventive care guidelines set by the U.S. Preventive Services Task Force, and provide and document the preventive care services required by the NCQA for HEDIS Quality Assurance reporting requirements

Provider creation and participation in individualized care plans

The individualized care plan is based on:

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

Provider participation as an integral member of the ICT. The ICT is a team of caregivers from different professional disciplines who work together to deliver care services that optimize quality of life and support the member and/or family.

The ICT may include and support the following:

- The member and/or his or her authorized caregiver
- The member's physicians and/or nurses
- Humana's care managers and coordinators
- Social workers and community social-service providers
- Humana's and/or the member's behavioral health professionals
- Humana's community health educators and resource-directory specialists
- The physician's goals via the Humana Cares team of nurses, social workers, pharmacy specialists and behavioral-health specialists
- Member education and enhancement of direct patient-physician communication
- Self-care management and informed healthcare decision-making
- Care coordination and care transitions
- Access and connections to additional community resources and Medicaid services
- Appropriate end-of-life planning
- Initiate or assist with the discharge or transfer of members from an inpatient facility to the most medically appropriate level-of-care facility or back to the member's home or permanent place of domicile. Consider the availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities
- Support, participate in, and communicate with the ICT, in person and/or in writing, in developing and implementing an individualized plan of care to facilitate effective care coordination
- Provide timely access to medical records or information for quality management and other purposes, including audits, reviews of Complaints or appeals, HEDIS, and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate.
- Follow the preventive care guidelines set by the U.S. Preventive Services Task Force, and provide and document the preventive care services required by the NCQA for HEDIS Quality Assurance reporting requirements.

Working with Demonstration members with a mental health diagnosis:

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

Understanding chronic conditions prevalent within the Demonstration population:

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

State transition of care requirements

To meet the transition of care requirements of the state, the following procedures will be followed by Humana and Carelon providers:

- In those instances when the member's care needs to be transitioned to a new provider or providers either during the transition period and once the transition period is over, the care coordinator follows the following procedures to ensure the member receives ongoing care:
  - Identify appropriate providers in the member's geographic area that meet cultural and linguistic needs
  - Review the list of recommended behavioral health providers with the member
  - Encourage member to select a recommended behavioral health provider, if unable, the care coordinator will select
  - Assist member in accessing an appointment with the identified provider
  - Obtain member permission to share relevant assessment findings with selected behavioral health provider

- Obtain member permission for the exchange of relevant health information between new behavioral health provider and PCP and other providers

Utilization management

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

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

- All mental health UM decisions are based upon Carelon's level of care/medical necessity criteria; substance abuse level-of-care decisions are made based on the American Society of Addiction Medicine criteria
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization

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

Community-based service providers

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

Level-of-care criteria (LOCC)

Carelon's LOCC are the basis for all medical necessity determinations; accessible through eServices, includes Carelon's specific LOCC for Illinois for each level of care. The following are Carelon's medical necessity criteria:

- CMS criteria
  - The Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Change Healthcare's InterQual® Behavioral Health Criteria
- American Society of Addiction Medicine (ASAM) Criteria
  - The American Society of Addiction Medicine (ASAM) Criteria focuses on substance use treatment
  - Unless custom criteria exist or for Substance Use Lab Testing (which is found in in InterQual® Behavioral Health Criteria), ASAM criteria is the criteria for substance use treatment services
- Carelon's National Medical Necessity Criteria

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

Utilization management terms and definitions

The definitions below describe utilization review that includes the various authorization request and UM determination types used to guide Carelon reviews and decision-making. All determinations are based upon review of the available information provided to Carelon at the time.

TABLE 3-8 UM TERMS AND DEFINITIONS	
Adverse benefit determination	• (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a Resident of a rural area with only one Demonstration Plan, the denial of an Enrollee's request to obtain services outside of the network; or (vii) the denial of an Enrollee's request to dispute a financial liability.
Adverse action	The following actions or inactions by Carelon or the provider organization: • Carelon's denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards • Carelon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service • Carelon's reduction, suspension or termination of a previous authorization for a service • Carelon's denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including, but not limited to, denials based on the following: - Failure to follow prior authorization procedures - Failure to follow referral rules - Failure to file a timely claim • Carelon's failure to act within the time frames for making authorization decisions • Carelon's failure to act within the time frames for making appeal decisions.
Non-urgent concurrent review and decision	Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non-acute treatment setting.
Non-urgent preservice review and decision	Any case or service that must be approved before the member obtains care or services. A non-urgent preservice decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in non-acute treatment setting.
Post-service review and decision (retrospective decision)	Any review for care or services that already has been received. A post service decision would authorize, modify or deny payment for a completed course of treatment where a preservice decision was not rendered, based on the information that would have been available at the time of a pre-service review.
Urgent care request and decision	Any request for care or treatment for which application of the normal time period for a non-urgent care decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment. In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment is requested.

TABLE 3-8 UM TERMS AND DEFINITIONS	
Urgent concurrent review decision	Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a member's condition meets the above definition of urgent care.
Urgent pre-service decision	Formerly known as a precertification decision, any case or service that must be approved before a member obtains care or services in an inpatient setting, for a member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment in an acute treatment setting.

Authorization procedures and requirements

This section describes the processes for obtaining authorization for inpatient, community-based diversionary and outpatient levels of care, and for Carelon's medical necessity determinations and notifications. In all cases, the treating provider (whether admitting facility or outpatient practitioner) is responsible for following the presented procedures and requirements to ensure payment for properly submitted claims.

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

Member eligibility verification

The first step in seeking authorization is to determine the member's eligibility. Since member eligibility changes occur frequently, providers are advised to verify a health plan member's eligibility upon admission to, or initiation of, treatment, and on each subsequent day or date of service to facilitate reimbursement for services. Member eligibility can change, and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Carelon's eServices or call IVR at **855-371-9234**.

Emergency services

Definition

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

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

Emergency screening and evaluation

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

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

Carelon clinician availability

All Carelon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Carelon clinicians are available 24 hours a day, seven days a week to receive crisis calls from providers for authorization of inpatient admission. Members and their guardians in emergency situations are directed to call Humana at **855-235-8530**.

Disagreement between physician adviser and attending physician

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

Authorization requirements

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

Outpatient treatment

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

Please refer to your contract for specific information about procedure and revenue codes that should be used for billing. Services that indicate "eRegister" will be authorized via Carelon's eServices portal. Providers will be asked a series of clinical questions to support medical necessity for the service requested. If sufficient information is provided to support the request, the service will be authorized. If additional information is needed, the provider will be prompted to contact Carelon via phone to continue the request for authorization.

While Carelon prefers providers to make requests via eServices, we will work with providers who do have technical or staffing barriers to requesting authorizations in this way.

Authorization decisions are posted on eServices within the decision time frames outlined in Table 3-9. Providers receive an email message alerting them that a determination has been made. Carelon also faxes authorization letters to providers upon request; however we strongly encourage providers to use eServices instead of receiving paper notices.

Providers can opt out of receiving paper notices on Carelon's eServices portal. All notices clearly specify the number of units (sessions) approved, the time frame within which the authorization can be used, and explanation of any modifications or denials. All denials can be appealed according to the policies outlined in this manual.
All forms can be found at carelonbehavioralhealth.com under "Provider".

Inpatient services

All inpatient services (including inpatient ECT) require telephonic prior-authorization within 24 hours of admission. Providers should call Carelon at **855-371-9234** for all inpatient admissions, including detoxification provided on a psychiatric floor or in freestanding psychiatric facilities and authorization for detoxification. Continued-stay reviews require updated clinical information that demonstrates active treatment. Additional information about what is required during preservice and concurrent stay reviews is listed below.

UM review requirements – inpatient and diversionary

The facility clinician making the request needs the following information for a pre-service review:

- Member's health plan Identification number
- Member's name, gender, date of birth, and city or town of residence
- Admitting facility name and date of admission
- DSMIV diagnosis: All five axes are appropriate; Axis I and Axis V are required. A provisional diagnosis is acceptable.
- Description of precipitating event and current symptoms requiring inpatient psychiatric care
- Medication history
- Substance use history
- Prior hospitalizations and psychiatric treatment
- Member's and family's general medical and social history
- Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment

To conduct a continued-stay review, call a Carelon UR clinician with the following required information:

- Member's current diagnosis and treatment plan, including physician's orders, special procedures and medications
- Description of the member's response to treatment since the last concurrent review
- Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan
- Report of any medical care beyond routine is required for coordination of benefits with health plan (routine medical care is included in the per diem rate)

Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, call Carelon. If the treatment rendered meets criteria for a post-service review, the UR clinician will request clinical information from the provider including documentation of presenting symptoms and treatment plan via the member's medical record. Carelon requires only those section(s) of the medical record needed to evaluate medical necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A Carelon physician or psychologist completes a clinical review of all available information to render a decision.

Authorization determinations are based on the clinical information available at the time the member care was provided. Members must be notified of all preservice and concurrent denial decisions. The service is continued without liability to the member until the member has been notified of the adverse determination.

The denial notification letter sent to the member or member's guardian, practitioner, and/or provider includes the specific reason for the denial decision, the member's presenting condition, diagnosis and treatment interventions, the reason(s) why such information does not meet the medical necessity criteria, reference to the applicable benefit provision, guideline, protocol or criterion on which the denial decision was based, and specific alternative treatment option(s) offered by Carelon, if any. Based on state and/or federal statutes, an explanation of the member's appeal rights and the appeals process is enclosed with all denial letters. Notice of inpatient authorization is mailed to the admitting facility. Providers can request additional copies of adverse determination letters by contacting Carelon.

Return of inadequate or incomplete treatment requests

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

Notice of inpatient/diversionary approval or denial

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

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

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

Termination of outpatient care

Carelon requires that all outpatient providers set specific termination goals and discharge criteria for members. Providers are encouraged to use the LOCC (accessible through eServices) to determine if the service meets medical necessity for continuing outpatient care.

Decision and notification timeframes

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

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

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

Request for reconsideration of adverse determination

If a health plan member or member's provider disagrees with a utilization review decision issued by Carelon, the member, his/her authorized representative, or the provider may request reconsideration. Please call Carelon promptly upon receiving notice of the denial for which reconsideration is requested.

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

TABLE 3-9 DECISION AND NOTIFICATION TIME FRAMES

	Type of decision	Decision time frame	Verbal notification	Written notification
Preservice review				
Initial authorization for other urgent behavioral health services	Urgent	Within 72 hours	Within 72 hours	Within 72 hours
Initial authorization for non-urgent behavioral health services	Standard	Within 14 calendar days	Within 14 calendar days	Within 14 calendar days
Concurrent review				
Continued authorization for inpatient and other urgent behavioral health services	Urgent/ expedited	Within 24 hours	Within 24 hours	Within 3 calendar days
Continued authorization for non-urgent behavioral health services	Non-urgent/ standard	Within 14 calendar days	Within 14 calendar days	Within 14 calendar days
Post service				
Authorization for behavioral health services already rendered	Non-urgent/ standard	Within 30 calendar days	Within 30 calendar days	Within 30 calendar days

Provider appeals

Provider appeals and grievance procedures

You have the right to file with Humana:

- A medical necessity appeal
- Please refer to Humana's Grievance and Appeals Procedures for further information.

You have the right to file with Carelon:

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

How to submit a provider appeal

Claim appeals:

Provider disputes may be submitted telephonically by calling the following number: **855-481-7044** between 7 a.m. to 6 p.m. Central time, Monday through Friday

Email :

Provider disputes submitted in writing need to be sent to the following address:
SoutheastServiceCenterPR@beaconhealthoptions.com

Fax:
Provider disputes may be submitted via fax to the following number: **305-722-3013**
Provider Portal: carelonbehavioralhealth.com
Click on "tools" and enter the health plan name, and then click "Claims"

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

- The member's name and Humana member ID number
- The provider's name and ID number
- The code(s) and reason why the determination should be reconsidered
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or electronic data interchange (EDI) for reconsideration
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification for reversing the determination

Mail: **Carelon Health Options**
P.O. Box 1856
Department
Hicksville, NY 11802-1856

Member grievance, appeals and fair hearing requests
Members have the right to file a grievance or appeal. They also have the right to request a state hearing once they have exhausted their appeal rights. Please refer to Humana's member grievance and appeals procedures for further information.

Carelon strongly encourages providers to rely on electronic submission, either through EDI or eServices to achieve the highest success rate of first-submission claims.

General claim policies

Carelon requires that providers adhere to the following policies with regard to claims:

Clean claims

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

Electronic billing requirements

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

Provider responsibility

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

Limited information use

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

Member billing prohibition

Providers are not permitted to bill health plan members under any circumstances for covered services rendered, excluding copayments when appropriate. See Prohibition on Billing members, for more information.

Carelon right to reject claims

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

Carelon recoupments and adjustments

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

Claim turnaround time

Clean claims will be adjudicated within 30 days from the date on which Carelon receives the claim.

Claims for inpatient services:

- The date range on an inpatient claim for an entire admission (i.e., not an interim bill) must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the "to" date. Refer to authorization notification for correct date ranges.
- Carelon accepts claims for interim billing that include the last day to be paid as well as the correct bill type and discharge status code. On bill type X13, where

X represents the “type of facility” variable, the last date of service included on the claim will be paid and is not considered the discharge day.

- Providers must obtain authorization from Carelon for all ancillary medical services provided while a health plan member is hospitalized for a behavioral health condition. Such authorized medical services are billed directly to the health plan.
- Carelon’s contracted reimbursement for inpatient procedures reflect all-inclusive per diem rates.

Coding

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

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes the appropriate HIPAA-compliant revenue, DSM, CPT, HCPCS and ICD codes. Providers should refer to exhibit A for a complete listing of contracted, reimbursable procedure codes.
- Carelon accepts only the appropriate ICD diagnosis codes listing approved by CMS and HIPAA. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.
- Claims for inpatient and institutional services must include the appropriate discharge status code and be billed in accordance with the National Uniform Billing Committee (NUBC) standards.
- All UB-04 claims must include the three-digit bill type code and be billed in accordance with the National Uniform Billing Committee (NUBC) standards.

Modifiers

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

TABLE 3-10 MODIFIERS

HIPAA modifier	Modifier description	HIPAA modifier	Modifier description
AH	Clinical psychologist	HR	Family/couple with client present
AJ	Clinical social worker	HS	Family/couple without client present
HB	Adult program, non-geriatric	HU	Funded by child welfare agency
HC	Adult program, geriatric	HW	Funded by state behavioral health agency
HD	Pregnant/parenting women’s program	HX	Funded by county/local agency
HE	Behavioral health program	SA	Nurse practitioner (This modifier required when billing 90862 performed by a nurse practitioner.)
HF	Substance use program	SE	State and/or federally funded programs/ services
HG	Opioid addiction treatment program	TD	Registered nurse
HH	Integrated behavioral health/ substance use program	TF	Intermediate level of care
HI	Integrated behavioral health and mental retardation/ developmental disabilities program	TG	Complex/high level of care
HK	Specialized behavioral health programs for high-risk populations	TJ	Program group, child and/or adolescent
HM	Less than bachelor degree level	UK	Service provided on behalf of the client to someone other than the client-collateral relationship
HN	Bachelor’s degree level	U3	Psychology intern

TABLE 3-10 MODIFIERS			
HIPAA modifier	**Modifier description**	**HIPAA modifier**	**Modifier description**
HO	Master's degree level	U4	Social work intern
HP	Doctoral level	U6	Psychiatrist (This modifier required when billing for 90862 provided by a psychiatrist.)
HQ	Group setting	UD	Substance abuse service

Time limits for filing claims

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

- Within 60 days of the dates of service on outpatient claims
- Within 60 days of the date of discharge on inpatient claims
- Providers are encouraged to submit claims as soon as possible for prompt adjudication.

Claims submitted after the 60-day filing limit will be denied unless submitted as a waiver or reconsideration request, as described in this chapter.

Coordination of benefits (COB)

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

- When it is determined that Carelon Health Options is the secondary payer, claims must be submitted with a copy of the primary insurance's explanation of benefits report and received by Carelon within 60 days of the date on the EOB.

Carelon Health Options reserves right of recovery for all claims in which a primary payment was made prior to receiving EOB information that deems Carelon the secondary payer. Carelon applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB.

Provider education and outreach

Summary

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

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

How the program works

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

Claim inquiries and resources

Additional information is available through the following resources:

Online at carelonbehavioralhealth.com/providers

- Carelon's claims page
- Read about eServices
- eServices User Manual
- Read about EDI
- EDI Transactions – 837 Companion Guide
- EDI Transactions – 835 Companion Guide

Email contacts

- SoutheastServiceCenterPR@beaconhealthoptions.com
- e-support.services@beaconhealthoptions.com

Telephone contact info

Interactive Voice Recognition (IVR): **855-371-9234**
You will need your practice or organization's Tax Identification Number, the member's identification number and date of birth, and the date of service.
Claims Hotline: **855-371-9234**
Hours of operation are Monday – Friday 7am-6pm
(An afterhours team is available until midnight to handle crisis calls)

Main Carelon telephone numbers

Provider relations **855-371-9234**
EDI **855-371-9234**
TTY **855-539-5884**
FAX **855-371-9232**

Electronic media options

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

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

Claim transaction overview

The following table identifies all claim transactions, indicates which transactions are available on each of the electronic media, and provides other information necessary for electronic completion. Watch for updates as additional transactions become available on EDI, eServices and IVR.

TABLE 3-11 CLAIM TRANSACTION OVERVIEW

Transaction	Access			When applicable	Carelon receipt timeframe	Other information
	EDI	eServices	IRV			
Member eligibility verification	Y	Y	Y	• Completing any claim transaction • Submitting clinical authorization requests	N/A	N/A
Submit standard claim	Y	Y	N	Submitting a claim for authorized, covered services, within the timely filing limit	Within 180 days of service date	N/A

TABLE 3-11 CLAIM TRANSACTION OVERVIEW

Transaction	Access			When applicable	Carelon receipt timeframe	Other information
	EDI	eServices	IRV			
Resubmission of denied clam	N	N	N	A first-time claim will be received by Carelon after the original 180-day filing limit and must include evidence that one of the following conditions is met: • Provider is eligible for retroactive reimbursement • Member was retroactively enrolled in the health plan • Services were retroactively authorized • Third-party coverage is available and billed first (a copy of the third-party insurance EOB or payment is required)	Within 180 days of qualifying event	Waiver requests will only be considered under circumstances: Any other requests will result in a claim denial on a future EOB • A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as a reconsideration request • A Carelon waiver determination is reflected on a future EOB with a message of Waiver Approved or Waiver Denied: if waiver of the filing limit is approved, the claim shows as adjudicated; if denied, the denial reason appears.
Request for reconsideration of timely filing limit	Y	N	Y	Claim falls outside of all time frames and requirements for resubmission, waiver and adjustment	Within 180 days from the day of payment or non-payment	Future EOB shows "Reconsideration approved" or Reconsideration denied"
Request for adjustment (corrected claims)	Y	Y	N	The amount paid to provider on a claim was incorrect Adjustment may be requested to correct: • Underpayment (positive request) • Overpayment (negative request)	Positive Carelon request must be received within 180 days from original payment date No filing limit for negative requests	Do NOT send a refund check to Carelon A rec ID is required to indicate that the claim is an adjustment Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount and, if the provider is owed money, claim payment for the correct amount. If an incorrect adjustment appears on an EOB, another adjustment request may be submitted based on the previous incorrect adjustment. Denied claims may be resubmitted, but not adjusted.
Obtain claim status	N	Y	Y	Available 24/7 for all claim transactions submitted by provider.	N/A	Claim status is posted within 48 hours after receipt by Carelon.
View/print remittance advice	N	Y	N	Available 24/7 for all claim transactions submitted by Carelon	N/A	Printable RA is posted within 48 hours after receipt by Carelon

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

Paper claim transactions

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

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

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

Detailed instructions for completing each form type are available at the following websites: CMS-1500 form instructions www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf

UB-04 form instructions nucc.org

Mail paper claims to:

Paper Claims
Carelon Health Options
Attention: Claims Department
P.O. Box 1870
Hicksville, NY, 11802-1870

Electronic Claims

Claims may be submitted directly to Carelon via an 837 file or via p provider website (registration required):
provider.beaconhs.com
Carelon Payer ID: 43324

Carelon does not accept faxed claims.

Paper resubmission

Carelon discourages paper transactions

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

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

- See Table 3-11 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Carelon more than 180 days from the date of service. The REC.ID from the denied claim line is required and may be provided in either of the following ways:
  - Enter the REC.ID in box 64 on the UB-04 claim form, or in box 19 on the CMS-1500 form
  - Submit the corrected claim with a copy of the EOB for the corresponding date of service
- The REC.ID corresponds with a single claim line on the Carelon EOB. Therefore, if a claim has multiple lines there will be multiple REC.ID numbers on the Carelon EOB.
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Carelon does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- Resubmissions must be received by Carelon within 180 days after the date on the EOB. A claim package postmarked on the 180th day is not valid.
- If the resubmitted claim is received by Carelon within 180 days from the date of service, the corrected claim may be resubmitted as an original. A corrected and legible photocopy is also acceptable.

Paper submission of 180-day waiver

- See Table 2-2 for an explanation of waivers (when a waiver request is applicable) and procedural guidelines
- Watch for notice of waiver requests becoming available on eServices.
- Download the 180-day waiver form.
- Complete a 180-day waiver form for each claim that includes the denied claim(s), per the instructions below.
- Attach any supporting documentation.
- Prepare the claim as an original submission with all required elements.
- Send the form, all supporting documentation, claim and brief cover letter to:
  Carelon Health Options
  Attention: Claims Department
  P.O. Box 1870
  Hicksville, NY 11802-1856

Completion of the waiver request form

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

1. **Provider name**
   Enter the name of the provider who provided the service(s).
2. **Provider ID number**
   Enter the ID number of the provider who provided the service(s).
3. **Member name**
   Enter the member's name and ID number.

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

Paper request for adjustment or void

Paper submissions have more fields to enter, a higher error rate, lower approval rate and slower payment. Carelon discourages paper transactions.

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

- See Table 3-11 for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines
- Do not send a refund check to Carelon. A provider who has been incorrectly paid by Carelon must request an adjustment or void.
- Prepare a new claim as you would like your final payment to be, with all required elements; place the Rec.ID in box 19 of the CMS-1500 claim form, or box 64 of the UB04 form
- Download and complete the Adjustment/Void Request Form per the instructions below.
- Attach a copy of the original claim.
- Attach a copy of the EOB on which the claim was erroneously paid or for an incorrect amount
- Send the form, documentation and claim to:
  Carelon Health Options
  Attention: Claims Department
  P.O. Box 1870
  Hicksville, NY 11802-1856

Completion of the Adjustment/Void Request Form:

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

1. **Provider name**
   Enter the name of the provider to whom the payment was made.
2. **Provider ID number**
   Enter the Carelon ID number of the provider who was paid for the service. If the claim was paid under an incorrect provider number, the claim must be voided and a new claim must be submitted with the correct provider ID number.
3. **Member name**
   Enter the member's name as it appears on the EOB. If the payment was made for the wrong member, the claim must be voided and a new claim submitted.
4. **Member identification number**
   Enter the plan member ID number as it appears on the EOB. If a payment was made for the wrong member, the claim must be voided and a new claim submitted.
5. **Carelon Record ID number**
   Enter the record ID number as listed on the EOB.
6. **Carelon paid date**
   Enter the date the check was cut as listed on the EOB.
7. **Check appropriate line**
   Place an "X" on the line that best describes the type of adjustment/void being requested.
8. **Check all that apply**
   Place an "X" on the line(s) which best describe the reason(s) for requesting the adjustment/void. If "Other" is marked, describe the reason for the request.
9. **Provider signature**
   An adjustment/void request cannot be processed without a typed, signed, stamped, or computer-generated signature. Carelon will not accept "Signature on file."
10. **Date**
    List the date that the form is signed.

Provider education of compliance-based materials

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

- Provider orientation
- Medicaid provider orientation
- Cultural Competency (required annually)
- Health, Safety and Welfare Education (required annually)

Click for information on
Humana's Cultural Competency Plan

Click for information on
Humana's Health, Safety and Welfare Training

Click for information on
Humana's Fraud, Waste and Abuse Training

Additional information on these topics is included in Humana's required annual compliance training as identified by Humana and Carelon. Please contact Carelon Provider Relations at **855-371-9234** or visit carelonbehavioralhealth.com/provider and click on "Tools" for help in understanding how to access this required training.

TABLE 3-12 AUTHORIZATION GUIDELINES (outpatient)		
Benefit/service	**Authorization requirement**	**Other information**
Medication Management (E/M)	None	
Psychiatric diagnostic interview with medical services	None	
Psychiatric diagnostic evaluation	None	
Injection administration	None	
Mental health/SA assessment	None	
Treatment plan development	None	
Group therapy	None	
Prenatal care at-risk assessment	None	
Individual psychotherapy	None	
Crisis intervention	None	
Family and marital therapy	None	
Medication administration	None	
Mental health risk assessment	None	
Case consultation	None	

Definitions

The following definitions are specific to this manual:

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

Agency – Illinois Department of Healthcare and Family Services (HFS)

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

Benefits – A schedule of healthcare member services covered by the health plan as set forth in manual Section I.

Children/adolescents – Members under the age of 21.

Complaint – A complaint is an informal component of the grievance system. Any oral or written expression of member dissatisfaction submitted to the health plan or a state agency. Possible complaint subjects include, but are not limited to:

- The quality of care
- The quality of services provided
- Aspects of interpersonal relationships (such as provider or health plan employee rudeness)
- Failure to respect member rights
- Health plan administration
- Claims, practices or provision of services related to the quality of provider care pursuant to the health plan contract

Contract(s) – The contract between U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) – in partnership with the Illinois Department of Human Services (HFS) — and Humana for the Medicare-Medicaid Alignment Initiative Demonstration (MMAI contract) regarding the provision of managed-care organization (MCO) health services.

County health departments (CHD) – CHDs are organizations administered by the state health department to promote public health, preventable disease control and eradication, and to provide primary healthcare for special populations.

Covered service – Aid provided by the health plan in accordance with its Demonstration contract, and as outlined in manual Section II under "Covered services."

Dual-eligible recipient – Any recipient deemed entitled to receive medical or allied care, goods or services covered under the state's contracted program. Eligibility is determined by the state or Social Security Administration on behalf of the state, pursuant to federal and state laws.

Consumer-directed (CD) model of services – The delivery template through which the member, that is eligible to receive services through a waiver, (or the member's employer of record, as appropriate), is responsible for the hiring, training, supervising, and firing of those who actually render state-reimbursed services.

Emergency medical condition – A level of health manifested by symptoms (which may include pain or other signs of illness) so severe that a prudent layperson with average health and medical knowledge could reasonably expect that a lack of immediate medical attention could lead to:

- Serious jeopardy to the health of a patient including a pregnant woman or fetus
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

With respect to pregnant women:

- Consideration of whether a transfer may pose a threat to the health and safety of the patient or fetus
- Examination of evidence of the onset and persistence of uterine contractions or rupture of other membranes

Emergency services and care – Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, other appropriate personnel under physician supervision, to determine whether an emergency medical condition exists. If an emergency condition exists, it includes the necessary available on-site treatment to relieve or eliminate the emergency medical condition.

Expanded services – A health plan-covered treatment for which the plan receives no direct agency payment.

External quality review organization (EQRO) – A group that meets the competence and independence requirements set forth in federal regulation 42 CFR 438.354, and performs external quality review (EQR), other related activities as set forth in either state or federal regulations, or both.

External quality review (EQR) – The analysis and evaluation by an EQRO of aggregated information on quality, timeliness and healthcare access furnished to Demonstration recipients by a health plan.

Grievance – An expression of dissatisfaction about any matter other than an action. Possible grievance subjects include, but are not limited to, quality of care, provided services and aspects of interpersonal relationships (such as provider or provider employee rudeness), or failure to respect member rights.

HFS —The Illinois Department of Healthcare and Family Services and any successor agency. In this Contract, HFS may also be referred to as "Agency" or "the Department". HFS includes any Person with which it may have a contract, or otherwise designate, to perform a HFS function under this Contract.

Home and community-based services (HCBS) waiver – Waivers under Section 1915(c) of the SSA that allow the State to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

Health plan – An entity that integrates financing, management and delivery of healthcare services to an enrolled population. It employs or contracts with an organized service provider system. A health plan also contracts with the state to provide Demonstration services, and includes health maintenance organizations (HMOs) authorized under the Illinois Health Maintenance Organization Act, (215 ILCS 125 et seq. of the Illinois statutes), exclusive provider organizations (EPOs) as defined in 50 Ill. Administrative Code 2051.220, and health insurers authorized under 215 ILCS 5/352 et seq. of the Illinois statutes.

Licensed – A facility, equipment or individual that meets formal state, county and local requirements.

Mandates – Applicable state and federal laws and regulations, including, without limitation:
- Medicaid and Medicare laws rules and regulations
- CMS requirements
- MMAI requirements and policies
- State and federal government sponsor orders, directives and requirements

Medicaid – The program under Title XIX of the SSA that provides medical benefits to eligible individuals, including certain people with low incomes.

Medicaid dual-eligible reform – MMAI changes resulting from 2013 CMS approval of joint plan implementation.

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

Medically necessary or medical necessity
This term refers to aid, supplies or medicines that:
- Are appropriate, reasonable and necessary for the diagnosis or treatment of illness or injury
- Improve the function of a malformed body part, or are otherwise medically necessary under 42 U.S.C.§1395y
- Are covered by the Illinois Department of Healthcare and Family Services
- Meet good medical practice standards in the medical community as determined by the provider:
  - Based on applicable standards of the care, diagnosis and treatment of a covered illness or injury in accordance with Demonstration plan guidelines, policies and procedures
  - As approved by CMS or the state
  - For the prevention of future disease

To assist in the member's ability to attain, maintain or regain functional capacity or achieve age-appropriate growth, plans will provide coverage in accordance with the more favorable of the current Medicare and Department coverage rules, as outlined in state and federal rules and coverage guidelines.

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

Member – A Demonstration recipient currently enrolled in the health plan.

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

Nursing facility – An institutional care facility that furnishes medical or allied inpatient care and services to individuals in need.

Outpatient – A patient of an organized medical facility or distinct part of that facility who receives (as expected by the facility) professional services for less than a 24-hour period without regard for admission hours, bed use or length of patient stay.

Participating specialist – A physician licensed to practice medicine in Illinois who contracts with the health plan to provide specialized medical services to plan members.

Patient-centered medical home (PCMH) – A healthcare setting that facilitates partnerships between individual patients, personal physicians and, when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchanges and other means to ensure that patients receive the needed indicated care when and where desired and in a culturally and linguistically appropriate manner. Participating PCMHs are required to manage and provide evidence-based services to members in order to integrate care with specialty and subspecialty practices.

Patient pay – The amount of the long-term services and supports (LTSS) member's income which must be paid as his/her share of the LTSS services expense.

Primary care – Comprehensive, coordinated and readily accessible medical care including health promotion and maintenance, illness and injury treatment, early detection of disease and specialist referral when appropriate.

Primary care provider (PCP) – A health plan staffer or contracted physician practicing as a general or family practitioner, internist, pediatrician or other state-approved specialty, who furnishes primary member care and patient management services. Pregnant members with chronic health conditions, disabilities or special healthcare needs may request that specialty or provider medical homes that furnish primary care and patient management services be designated as their PCP. Homebound members or members with significant mobility limitations may request that primary care services be furnished by nurse practitioners or physicians through home visits.

Preauthorization – Health plan approval of specific services before they are rendered.

Protocols – Written guidelines or documentation outlining actions for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and/or educational services.

Provider – A person or entity that meets all state and/or federal requirements (as appropriate) to provide covered services to Demonstration members.

Participating provider (or network provider) – A contracted healthcare provider who is under a currently valid provider agreement to participate in a health plan's Medicare Advantage and/or Medicaid networks serving Demonstration members.

Provider contract – An agreement between the health plan and a provider as described above.

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

Quality Improvement (QI) – The process of monitoring and ensuring that available, accessible, timely, medically necessary member healthcare and need-appropriate services is provided in sufficient and acceptable quantity and quality, and within established excellence standards.

Quality Improvement Program (QIP) – The process of ensuring delivery of appropriate, timely, accessible, available and medically necessary healthcare.

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

State – State of Illinois.

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

Subcontractor – Any person or entity with which the health plan has contracted or delegated some of its state-contracted functions, services or responsibilities for providing services.

Transportation – An appropriate means of member-needed conveyance to obtain plan-covered services.

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

Well-care visit – A routine medical visit for one of the following: family planning, routine follow-up for previously treated conditions or illnesses, adult physicals or any routine visit for other-than-illness treatment.