



Provider Manual

For physicians, hospitals and healthcare providers

Humana[®]

Table of contents

Overview of Humana, ChoiceCare and Humana Behavioral Health4-5

Contact Information6-7

- Online Provider Portals6
- Contact Us7

Claims Procedures8-15

- Checking Member Eligibility8
- Member Identification (ID) Card8
- Humana Access Cards9-10
- Medical Coverage Policies, Clinical Trials10
- Claims Submission and Processing10-13
- Reimbursement13-14
- Overpayments: Humana Provider Payment Integrity14-15

Pharmacy15

Utilization Management15-21

- Preauthorization (Prior Authorization)15-16
- Referrals16-17
- Inpatient Coordination of Care/Concurrent Review17
- Clinical Review Guidelines17-18
- Peer-to-peer Review18
- Second Medical Opinions18
- Special Requirements for Hospitals18-20
- Special Requirements for SNFs, Home Health and Outpatient Rehab20-21

Office Procedures21-22

- Office Appointments and Wait Times21
- Address Change and Other Practice Information21-22

Medical Records22

Provider Claims Dispute Process, Member Grievance/Appeal Process and Provider Termination Appeal Process22-26

- Provider Claims Dispute Process22-23
- Member Grievance/Appeal Process23-24
- Commercial Appeals24
- Medicare Appeals25
- Provider Termination Appeal Process25-26

Covered Services26

Clinical and Behavioral Health Practice Guidelines26

Compliance/Ethics26-30

- Liability Insurance26
- Compliance and Fraud, Waste and Abuse Requirements26-27
- Medicare27-30

Product/Plan Overview30-32

- Health Maintenance Organization (HMO) ...30-32
- Preferred Provider Organization (PPO)32

Credentialing32

Quality Management32-33

Population Health Management33-35

- Population Health Management33
- Case Management Programs33-35

Humana EAP Section35-36

- Humana Employee-assistance Program (EAP) and Work-life Services35
- Contact Us35
- Clinical Services35
- Claims Procedures35-36

Rights and Responsibilities36-40

- Physicians'/Providers' Rights and Responsibilities36-39
- Members' Rights and Responsibilities39-40

Accreditation40-41

Delegation41

State-specific Provisions41

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Overview of Humana, ChoiceCare and Humana Behavioral Health

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

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

Humana Behavioral Health Network: Health Value Management Inc., d/b/a Humana Behavioral Health Network (HBHN), is a wholly owned subsidiary of Humana Inc. HBHN is Humana's behavioral health network that includes more than 60,000 providers and 1,800 facilities across all 50 states and the District of Columbia. Provider participation agreements are written with fully licensed healthcare professionals, psychiatrists, hospitals and facilities in all states. HBHN serves small and large group health plans as well as self-insured employers, insurance companies, government agencies, third-party administrators, and other similar entities as customers.

Note: Humana contracts with numerous other providers for participation in Humana's provider networks that are not part of the ChoiceCare or Humana Behavioral Health (HBHN) networks.

Please note that ChoiceCare and HBHN are not insurance companies, health plan administrators or other payers and are solely rental networks as described above.

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

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

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

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

Variations in applicable laws, regulations and governmental agency guidance including, but not limited to, state or federal laws, regulations and/or changes to such laws, regulations or guidance may create certain requirements related to the content in this manual that are not expressly set forth in this manual.

Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this manual are incorporated herein by this reference and shall apply to providers and/or Humana where applicable. Such laws and regulations, if more stringent, take precedence over the content in this manual. Providers are responsible for complying with all laws and regulations that are applicable.

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

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

Responsibility for Provision of Medical Services:

Providers are independent contractors and are solely responsible to members for the provision of health services and the quality of those services. This means providers and Humana do not have an employer-employee, principal-agent, partnership, joint venture or similar arrangement. It also means that providers have a duty to exercise independent medical judgment to make independent healthcare treatment decisions, regardless of whether a health service is determined to be a covered service. Nothing in the agreement or this manual is intended to create any right for Humana to intervene in the provider's medical decision-making regarding a member.

Additionally, providers are responsible for the costs, damages, claims and liabilities that arise out of their own actions. Humana does not endorse or control the clinical judgment or treatment recommendations made by providers.

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

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

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

Humana Plans: Humana offers a variety of health plans through its insurance subsidiaries; however, not all plans are available in all markets. For more information on the health plans available in your area visit our website for provider resources.

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

Humana

**National Network Operations – HUM 07
500 W. Main St.
Louisville, KY 40202**

Contact information

Online Provider Portal and Information

Providers can visit [Humana.com/providers](https://www.humana.com/providers), our public provider site (registration not required), to find important information. These pages provide a variety of informational resources including, but not limited to, Humana's drug list and links to clinical practice guidelines. Please see the list below for additional resources available on these pages.

Providers can log into [Availity.com](https://www.availity.com) (registration required) to access a number of transactional features including, but not limited to, the following: validate member eligibility, check claim status, enter a referral, initiate and complete a preauthorization request, update demographics and upload clinical information as needed.

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

Clinical and Healthcare Resources:

Quickly locate details about [Humana's clinical practice guidelines](#), patient health education, clinical services and innovation, transplant services, bariatric services and disease management programs.

- **[Continuing Medical Education \(CME\) Opportunities:](#)** Find online opportunities to learn the latest information and recommendations regarding healthcare best practices.
- **[Provider Medicare Information:](#)** Provides more information about plans offered in specific areas.
- **Preauthorization List:** Provides a comprehensive list of services and medications outlining which services and plans require preauthorization or notification. ([Humana.com/PAL](https://www.humana.com/PAL))
- **Provider Appeal Process:** Provides an explanation of the [appeals process](#) for physicians and other healthcare providers.
- **Credentialing Services:** Council for Affordable Quality Healthcare (CAQH) – Provides a link to CAQH's Universal Credentialing Data source.
- **Provider Web-based Tutorials and Educational Materials:** Get the most out of Humana's web tools by attending a provider webinar session. The ["Making It Easier"](#) series includes narrated video presentations that address a variety of claims policy and process questions, as well as other topics of interest to providers of all types.
- **Provider Onboarding and Support Materials:** [Educational tools](#) that are available on demand.
- **Resources for Humana-covered Patients:** Learn more about services that may benefit patients with Humana plans.

- **Prescription Tools and Resources:** Learn more about Humana's pharmacy programs by using the [drug list search, prescription tools and resources and pharmacy locator](#).
- **Claims Processing Edit Updates:** Access summaries of changes planned for our claims payment systems at [Humana.com/Edits](https://www.humana.com/Edits).
- **Claims Payment Policies:** Learn about acceptable billing practices and reimbursement at [Humana.com/ClaimPaymentPolicies](https://www.humana.com/ClaimPaymentPolicies).
- **Humana Physician News:** Quarterly email newsletter for network physicians, clinicians and office staff. Features the latest news, resources and administrative information to support you in the care of your Humana-covered patients. See the latest newsletter and subscribe at [Humana.com/physiciannews](https://www.humana.com/physiciannews).
- **Electronic claims payment:** Review enrollment options and advantages at [Humana.com/ePaymentInfo](https://www.humana.com/ePaymentInfo).
- **Working with Humana online:** Visit [Humana.com/ProviderSelfService](https://www.humana.com/ProviderSelfService) to find information on how to access secure online tools, or register for a webinar at [Humana.com/ProviderWebinars](https://www.humana.com/ProviderWebinars).

Availity Portal (registration required)

The multi-payer Availity Portal at [Availity.com](https://www.availity.com) offers online tools to help healthcare professionals, including third-party administrators, to streamline administrative tasks, such as those listed below.

- Check eligibility and benefits
- Access certificates of coverage
- Submit a referral or preauthorization request
- Answer questions and get real-time approval for preauthorizations or attach clinical information for quicker processing
- Check the status of an authorization
- Check claim status
- View or download remittance advice
- Respond to medical record requests
- Manage overpayments
- Request electronic remittance advice and electronic funds transfer (ERA/EFT) enrollment
- Use the Code Edit Simulator tool
- Access the provider directory
- Update demographics
- Find Humana-specific apps, resources and news

Contact us

Case Management: Refer to the [Population Health Management section](#) for more detailed information.

Electronic Data Interchange (EDI): To exchange information with Humana quickly and efficiently, providers are encouraged to use EDI transactions, such as the following:

- Healthcare Claim: Professional (837p)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Review and Response (278)
- Healthcare Services Inquiry and Response (278)

For additional transactions and detailed information, visit [Humana.com/EDI](https://www.humana.com/EDI)

Fraud, Waste and Abuse: Humana Hotline: **800-614-4126**

Humana Access Card: **800-604-6228** (Humana's Spending Account Administration team)

Humana Customer Service: Call **800-457-4708** or the number listed on the back of the patient's Humana ID card for assistance with questions regarding:

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

Member Eligibility Inquiries:

- Visit the Availity Portal at [Availity.com](https://www.availity.com), or
- Submit a B2B or batch Health Care Benefit Inquiry and Response transaction (270/271) via EDI, or
- Telephone:
 - Commercial members call **800-4HUMANA (800-448-6262)**
 - Medicare Advantage members call **800-457-4708**
 - Florida Medicaid members call **800-477-6931**
 - Illinois Medicaid members call **800-787-3311**
 - Kentucky Medicaid members call **800-444-9137**
 - South Carolina Medicaid members call **866-432-0001**

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

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

Preauthorization and Referral Submissions and Inquiries:

- Access the Availity Portal at [Availity.com](https://www.availity.com).
 - Submit a B2B or batch Health Care Services Review and Response transaction (278) via EDI, or
 - Telephone **800-523-0023**
 - The list of services requiring authorization can be found at [Humana.com/PAL](https://www.humana.com/PAL)
-

Provider Relations: Humana, ChoiceCare or HBHN: **800-626-2741**, 8 a.m. to 5 p.m. Central time

- Participating/non-participating inquiries
- Allowed amounts and fee schedules
- Copy of contract and effective dates

Claims procedures

Checking Member Eligibility

Web:

Access the Availity Provider Portal at [Availity.com](https://www.availity.com).

Phone:

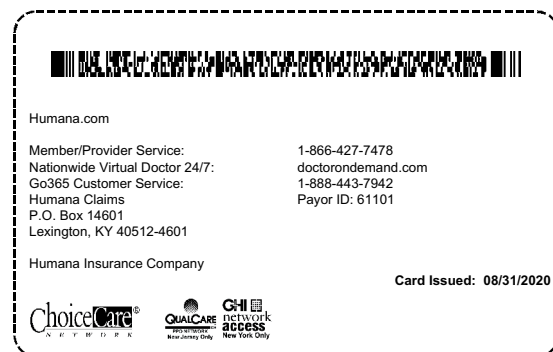
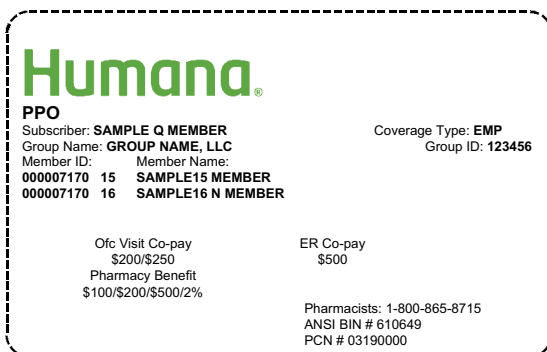
- Call Humana Customer Service at **800-457-4708** or the number on the back of the patient's Humana ID card.
- Provide the subscriber's identification number and other authentication information.

ChoiceCare and HBHN are provider networks, not insurance companies, health plan administrators or other payers and, therefore, does not provide verification of member eligibility and benefits. The member ID card bears the name and logo of the insurance company or plan administrator to contact to verify benefits and eligibility. The verification phone number and/or website address also can be found on the member ID card.

Member Identification (ID) Card

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

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



When applicable, a copayment is collected from the patient at the time of service. Copayment amounts for office visits and prescriptions are listed on the member's ID card. Because copayments are subject to change, please verify the amounts via the Availity Provider Portal or by calling the number listed on the back of the member's ID card.

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

Humana Access Spending Account Card

Humana Access cards are issued to members with health savings accounts (HSA), health reimbursement arrangements (HRA) or flexible spending accounts (FSA). The card can be used at physician offices, medical labs, hospitals and for other eligible medical expenses. This card enables the member to access HSA, HRA or FSA funds. It is not a medical ID card; members will have separate medical insurance ID cards. Below is a sample of the Humana Access card:



Please note the following:

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

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

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

Ways to use the Humana Access card: There are two distinct ways the card should be charged for medical expenses.

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

1. **Copayments at time of visit:** Swipe the member's card upfront at the time of visit for copayments only. (Note: Some plans do not have a copayment.) Press the credit key even though it is a debit card.
2. **Coinsurance and deductibles after the office visit:** When the remittance process provides the member-owed portion of the claim, key in the number and expiration date. The member's card is automatically charged.

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

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

Member overpayments and credits to Humana Access cards:

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

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

To avoid overcharging, Humana recommends waiting until the claims adjudication process is complete before portions of the deductible or coinsurance are charged to the card.

For assistance with problems in processing a member's payment with the Humana Access card, call Humana's Spending Account Administration Team at **800-604-6228**.

Humana Access Spending Account Non-Carded (auto-pay HRA)

Humana Access Spending Account Administration also offers non-carded HRAs to employers. If a subscriber participates in one of these accounts, they may present a letter with their deductible amount and their employer's annual election (funded) amount. These accounts are setup to automatically reimburse (auto-pay) providers for eligible expenses, but it may take several business days for the funds to transfer.

Medical Coverage Policies, Clinical Trials

Humana's medical coverage policies are available on [Humana.com/Provider> Medical Resources> Preauthorization & Referrals> Coverage Policies](https://www.humana.com/Provider/MedicalResources/Preauthorization%20and%20Referrals/CoveragePolicies)). See ["Utilization Management, Clinical Review Guidelines"](#) for further information about Humana's medical coverage policies. The medical coverage policy specific to clinical trials contains the details on the codes that are to be billed when services are provided as part of a clinical trial. For claims to be paid properly, a provider must include these codes on the claims submission.

Claims Submission and Processing

Claims Submission: Unless applicable law provides that submissions can be in paper format, providers must submit all claims, encounters and clinical data to Humana by electronic means. Those electronic means accepted as industry standard may include claims clearinghouses

or electronic data interface companies used by Humana. Providers using electronic submission must submit all claims to Humana or its designee, as applicable, using the HIPAA-compliant 837 electronic format. When the 837 standard electronic format requires the submission of a taxonomy code from one or more providers, a taxonomy code must be submitted for each provider, and the taxonomy code must be the code most appropriate for that provider and the services provided.

Provider acknowledges that Humana may market certain programs and/or products that will require electronic submission of claims and clinical data for the provider to participate. Providers must notify Humana when they have completed their transition to electronic medical records and agree to provide information on the status to Humana upon request. Unless applicable law mandates that submission may be in paper format, the provider must submit to Humana all Humana-required clinical data (including, but not limited to, laboratory data) by available electronic means within 30 days of the date of service or within the time specified by applicable law. When submission of a paper form is permissible, providers must submit claims using an original CMS-1500 and/or an original UB-04 form, or their successors.

Humana expects that all services resulting in the generation of a lab result require the provider to submit the corresponding lab results data electronically to Humana within 30 days of the patient's date of service. The lab results data must be submitted electronically in Humana's standard file layout ([Humana.com/marketing/documents.asp?file=2098642](https://www.humana.com/marketing/documents.asp?file=2098642)) and include the correct Logical Observation Identifiers Names and Codes (LOINC) and other values associated with the result in the correct data format as outlined in Humana's standard file layout. Submission must be made through one of Humana's approved methods as outlined on the Humana provider website.

Provider's failure to comply with claims, encounters and lab results data submission guidelines may result in a reduction of the amount, if any, which otherwise would be due under this agreement for the service. A reduction in the capitation payment amount may be applicable to capitated providers.

This data will be used within the guidelines allowed by HIPAA and the Genetic Information Nondiscrimination Act (GINA) and applicable state laws, if any. This data allows Humana to comply with accreditation and regulatory requirements established by the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) and/or other regulatory

agencies. This data also may be used to establish member clinical profiles, to more easily and quickly predict disease progression and reduce acuity, as well as to calculate Healthcare Effectiveness Data and Information Set (HEDIS®) qualitative scores and other member-related initiatives.

Submit paper claims to the address listed on the back of the member's ID card or to the appropriate address listed below:

Humana Medical Claims:

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

Humana Encounters:

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

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

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

Note: The RTA process may not work for every claim. If not, please use the normal adjudication process and receive payment through the usual process.

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

- The claim must be submitted either electronically or by paper if permitted by applicable law.
- The claim must be "complete" and must qualify as a "clean claim."
 - Complete – the information provided in the claim

must be sufficient to substantiate the services rendered to the Humana-covered patient.

- Clean claim – the claim must satisfy the description set forth in state or federal law, as applicable, based upon the type of plan.
- A member's original signature, or a "signature on file" or "assignment on file" stamp, is required for payments made directly to the provider.

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

- Separate charges must be itemized on separate lines. See the providers' section of Humana.com for Humana's [claims payment policy](#) on itemized bills. Medical record documentation must validate the scope of services provided and billed.
- The time frame for submitting claims is listed below, if not otherwise specified by the agreement or applicable state or federal law:
 - Commercial lines of business: 90 days from date of service
 - Medicare lines of business: one year from date of service
 - Medicaid lines of business: Refer to the state-specific Medicaid [provider manual](#).

Specialist Providers: For commercial HMO and Medicare Advantage HMO, reimbursement for specialist services is dependent upon referral authorization and corresponding documentation. All specialist claims must include a referral authorization number, when applicable, or an inpatient authorization number. The referral authorization or inpatient authorization number must be shown in Box 23 of the CMS-1500 Claim Form or Box 64 of the UB04 Claim Form or loop 2300/REF02 segment, which is the equivalent electronic submission field. For additional information, see the [Referrals section](#) of this manual. See the providers' section of Humana.com for [Humana's claims payment policy](#) on ordering and referring provider requirements.

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

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

Note: If the inpatient authorization number is not on the

claim, the claim may be denied. The member cannot be balance billed for this type of denied claim.

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

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

Such claims processing procedures include review of the interaction of a number of factors. The result of Humana's claims processing procedures will be dependent upon the factors reported on each claim. Accordingly, it is not feasible

to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
 - Two or more surgeries performed the same day
 - Two or more endoscopic procedures performed the same day
 - Two or more therapy services performed the same day
- Whether a co-surgeon, assistant surgeon, surgical assistant or any other provider who is billing independently is involved
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under one billing code

Humana develops claims processing procedures in our sole discretion based on our review of correct coding initiatives, national benchmarks, industry standards, and industry sources such as the following, including any successors of the same:

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

Changes to any one of the sources may lead Humana to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records, prior to or after payment, or the recoupment or refund request of a previous reimbursement. Providers may access additional information on Humana's website at **Humana.com**. An adjustment in reimbursement as a result of claims processing procedures is not an indication that the service provided is a non-covered service. Providers may submit a dispute request of any adjustment produced by these claims processing procedures by submitting a timely request to Humana. For additional information, see the [Provider Claims Dispute Process](#) section of this manual and the providers' section of Humana.com for [Humana's claims payment policy](#) on claim disputes.

Pass-through Billing: Humana prohibits pass-through billing. Pass-through billing occurs when a provider bills

for a service that was not performed by that provider or any individual under that provider's direct employment. Pass-through billing services will not be eligible for reimbursement from Humana, and the provider shall not bill, charge, seek payment or have any recourse against Humana or members for any amounts related to the pass-through billing provision. See the providers' section of Humana.com for [Humana's claims payment policy](#) on pass-through billing.

Medicare Secondary Payer: Humana MA plans are required to follow the Medicare Secondary Payer rules established for the Medicare program. Humana expects providers to abide by the Medicare Secondary Payer billing requirements when submitting claims to Humana MA plans. For guidance on the Medicare Secondary Payer provisions and billing requirements, see CMS's [Medicare Secondary Payer Booklet](#) and the [Medicare Secondary Payer Manual](#).

Reimbursement

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

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

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

A provider who receives reimbursement for services rendered to a Humana Medicare Advantage-covered

patient must comply with all federal laws, rules and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil Rights Act of 1964, Rehabilitation Act of 1973, Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990.

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

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

Electronic Claims Payment: For information about electronic claims payment, including electronic remittance advice and electronic fund transfer (ERA/EFT), visit [Humana.com/ePaymentInfo](#). When you enroll in EFT, Humana claims payments are deposited directly into the bank account(s) of your choice. You can access your ERA through your clearinghouse or through the secure provider tools available at the [Availity Provider Portal](#).

Request for Claims Dispute: If a provider disagrees with how Humana has adjudicated a claim, the provider should follow the procedures set forth in the [Provider Claims Dispute Process](#) section of this manual or any applicable state laws. See the providers' section of Humana.com for [Humana's claims payment policy](#) on claim disputes.

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

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

Services That Are Not Medically Necessary: When Humana determines that rendered services covered under the terms of the applicable member plan were not medically necessary, the provider shall not bill, charge, seek payment or have any recourse against the member for such services.

Therapy Assistant: Effective for dates of service beginning Jan. 1, 2022, claims processing procedures apply to occupational and physical therapy services provided in whole or in part by an occupational therapy assistant or physical therapy assistant. See the providers' section of [Humana.com](#) for [Humana's claims payment policy](#) on therapy assistants.

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

- **Assistant at Surgery:** When a physician or non-physician practitioner (NPP) actively assists the primary surgeon, Humana reimburses the assistant at surgery services per the assistant-at-surgery agreement and Humana's claims payment policy. It is the responsibility of the participating primary surgeon to select a participating assistant at surgery.
- **Bilateral surgery:** When procedures are performed on both sides of the body during the same operative session by the same physician, a bilateral payment adjustment may apply, based on provider's agreement and Humana's claims payment policy.
- **Co-surgeon:** When one of two or more health care practitioners furnishing a single surgery which requires the skill of multiple surgeons, each in a different specialty, performing parts of the same surgery simultaneously. Humana reimburses the co-surgeon services per each co-surgeon's agreement and Humana's claims payment policy.

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

Overpayments: Humana Provider Payment Integrity

Overview: Humana Provider Payment Integrity (PPI) reviews Humana's claims payments for accuracy and requests refunds if claims are overpaid or paid in error.

Contacts, General Inquiries and Escalation Process: For more information on how to resolve recoupment concerns, such as overpayments, payment integrity reviews, disputes and medical record requests, please visit [Humana.com/provider/medical-resources/payment-integrity-and-disputes](#).

Provider Payment Integrity Medical Record Review

Process: Humana operates a review program to detect, prevent and correct fraud, waste and abuse and to facilitate accurate claim payment. For more information, please visit [Humana.com/provider/medical-resources/payment-integrity-and-disputes/medical-record-review-resources](https://www.humana.com/provider/medical-resources/payment-integrity-and-disputes/medical-record-review-resources).

Pharmacy

Humana's pharmacy processes are found in the Humana Pharmacy Manual – Medicare and Commercial.

The manual includes information on the following:

- How to join our network
- Contact information
- Eligibility verification
- Drug coverage
- Claims procedures
- Controlled substances
- Medicare claims coverage
- Long-term care
- Home infusion billing procedures
- Compound claims
- Medication Therapy Management (MTM) Program
- Pharmacy audit and compliance
- Complaint system
- Price Source and MAC information
- Medicare's Limited Income NET Program (LINET)

In outpatient hospital places of service, certain specialty drugs administered to Humana commercial insurance members must be sourced through a Humana network pharmacy, like Humana Specialty Pharmacy. The list of these medications may be reviewed within the Commercial PAL. These requirements are outlined in Humana's clinical policy Site of Care and Specialty Medication Sourcing for Injectable Drugs. Failure to source the medication as outlined in our policy will result in a denied reimbursement.

Utilization Management

Our Utilization Management (UM) Program is designed to ensure Humana 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 facilitating 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. Humana does not reward doctors, other individuals or Humana employees for denying coverage or encourage under use of services.

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.

Medical services and mental health/substance use disorders services are evaluated for addition or removal, utilizing the same factors in accordance with the Federal Mental Health Parity Addiction and Equity Act (MHPAEA).

Our preauthorization list is at [Humana.com/PAL](https://www.humana.com/PAL). You also can call Customer Service (800-4HUMANA) to request a hard copy of the list. Please note that the preauthorization list is subject to change. Medical services and mental health/substance use disorders services are evaluated for addition or removal, utilizing the same factors in accordance with the Federal Mental Health Parity Addiction and Equity Act (MHPAEA).

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 required, providers must 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 should:

- Sign in at [Availability.com](https://www.availability.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 pending 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; for Behavioral Health authorizations, fax the request to 469-913-6941.

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

Information Required: 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
 - Long-term acute care
 - Rehabilitation
 - Behavioral health
 - Outpatient
 - Telehealth
 - Office
 - Home
 - Off-campus outpatient hospital
 - On-campus outpatient hospital
 - Ambulatory surgery center
 - Observation
- Type of authorization – inpatient or outpatient
- Tax ID Number (TIN) and National Provider Identifier (NPI) number of requesting provider
- TIN and NPI of treatment facility where service is being rendered
- TIN 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

Submitting all relevant clinical information at the time

of the request will facilitate a quicker determination. If Humana requires additional clinical information, a Humana representative will request the specific information needed to complete the authorization process.

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

CMS does not permit any provider to use the Advance Beneficiary Notice (ABN) for a Medicare Advantage plan enrollee. However, as with Original Medicare, if a provider thinks a specific service might not be covered, CMS expects the provider to share that information with the patient before providing the service. Note that for contracted providers particularly, CMS has established very specific requirements for such services. Before providing a service that might not be covered, you should call Humana to request an ACD/predetermination, unless the member's plan certificate clearly indicates that the service is never covered. For procedures or services that are investigational, experimental or may have limited benefit coverage, or if you have questions regarding whether Humana will pay for any service, you can request an ACD on behalf of the patient prior to providing the service. You may be contacted if Humana needs additional information.

ACDs for medical services can be submitted in writing, by fax or by telephone.

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

ACDs for medications on the list can be submitted by fax or telephone:

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

Referrals

For patients with Health Maintenance Organization (HMO) plans, referrals may be required. 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.

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 Medicare Advantage members, Humana follows Original Medicare billing and enrollment requirements for services and supplies covered under Original Medicare.

Inpatient Coordination of Care/Concurrent Review

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

In addition to the information provided for the initial admission, providers should indicate any complicating factors that prevent discharge. Providers also must contact Humana with the discharge date and discharge disposition upon patient discharge.

For certain plans, in the event coverage guidelines for an inpatient stay are not met and/or the member's certificate does not provide the benefit, a licensed medical professional from Humana will consult with the PCP and/or facility utilization management and discharge planning

staff. If necessary, the licensed medical professional will refer the case to a health plan medical director for review and possible consultation with the attending physician. If the medical director determines that coverage guidelines for continued hospitalization no longer are valid, the patient, attending physician, hospital and the patient's primary care office, as appropriate, will be notified in writing that benefits will not be payable if the patient remains in the hospital on and after the effective date of the non-approval.

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. Humana also develops internal clinical policies, Humana Medical Coverage Policies (HMCPs), which are used for both Medicare and commercial plans and based on peer-reviewed literature. [View Humana's Medical Coverage Policies](#).

For Medicare Advantage plans, Humana also applies Medicare guidelines, national coverage determinations (NCDs) and local coverage determinations (LCDs). Humana maintains corporate licensure for use of MCG® care guidelines. MCG care guidelines and Technology Assessment Forum research are made available, either verbally or in writing, to practitioners and members, upon request.

Prior to an adverse medical necessity determination, 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.

Any clinical criteria used in making UM determinations are available on request by contacting our Utilization Management department:

Send written requests to the following address:

Humana Correspondence

P.O. Box 14601

Lexington, KY 40512-4601

Submit by fax: **800-266-3022**

Submit by phone: **800-523-0023**

Peer-to-peer Review

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

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

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

- Physician/provider is contracted with Humana.
- Humana’s adverse determination was based on lack of medical necessity for an authorization request that was retrospective (retro) or concurrent to the service.

Physicians/providers 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. See the [Provider Claims Dispute Process](#) section of this manual.

Commercial Plans: For fully insured commercial plans issued in Texas and Arizona, state regulations require any determination beyond the initial determination to be processed as an appeal. Therefore, the peer-to-peer discussion must be completed prior to the initial adverse determination.

Participating providers can submit a claim dispute. See the [Provider Claims Dispute Process](#) section of this manual.

Second Medical Opinions

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

- Surgical procedures

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

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

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

Hospital Discharge Rights for Medicare Advantage

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

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

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

If the hospital staff is unable to personally deliver the IM to the patient or his/her representative, then the hospital staff should telephone the patient or 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 member or representative contacted by phone, the date and time of telephone contact and the telephone number called.

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

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

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

When the CMS Quality Improvement Organization (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.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html).

Medicare Outpatient Observation Notice (MOON)

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

Important information:

- Effective March 8, 2017, hospitals and CAHs are responsible to provide the written MOON and a verbal explanation of the notice to all Original Medicare and MA beneficiaries who receive outpatient observation services for more than 24 hours.
- The MOON must be provided to the beneficiary (or the beneficiary's authorized representative) no later than 36 hours after observation services begin and may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.
- If the beneficiary is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.

- The start time of observation services is measured as the clock time observation services are initiated in accordance with a physician's order.
- Hospitals and CAHs must use the Office of Management and Budget (OMB)-approved MOON (CMS-10611) and instructions available on the CMS website at [cms.gov/Medicare/Medicare-General-Information/BNI](https://www.cms.gov/Medicare/Medicare-General-Information/BNI).

Additional information about the MOON can be found on the CMS Medicare Learning Network site (MLN Matters No. 9935) at [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9935.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9935.pdf)

Special Requirements for Skilled Nursing Facilities, Home Health Agencies and Comprehensive Outpatient Rehabilitation Facilities – Medicare Advantage plan members

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

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 MA 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 that is delegated to the practitioner to complete) to members or their authorized representatives no later than close of the calendar day on which they are notified, including on weekends and holidays. The DENC provides specific and detailed information concerning why the SNF, HHA or CORF services are ending.

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

For more information about notification of termination requirements, practitioners can visit the CMS website at: [cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html).

Office Procedures

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

Office Appointment and Wait Times

Providers should implement procedures and make reasonable efforts to ensure that:

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

Address Change or Other Practice Information

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

If a provider's agreement with Humana is through a management services organization (MSO), independent practice association (IPA), or provider medical group, these changes can be communicated to Humana through the entity rather than by the individual provider. For group practices, directories must only list individual providers at locations where they routinely see patients by appointment, as opposed to every location of the group.

Please note, changes can be completed much quicker when contacting Humana directly.

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

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

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

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

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

When physicians and other healthcare professionals need to update their demographic information (e.g., correct a provider practice name or address, add physicians to a practice, update facility hours of operation, notify that the practice is accepting new patients, etc.), they can do so through [Availity.com](https://www.availity.com) or they can refer to this [list of contacts by region](#). Submitting these updates to the correct contact will help Humana quickly update its provider directories, which means Humana members can easily locate the correct information.

If you need a template format on which to submit demographic information, please use the preferred standard roster template at apps.humana.com/marketing/documents.asp?file=3542708. You can submit the template by [contacting your regional contracting representative](#).

Physicians and other healthcare professionals can view their practice or facility information on Humana’s online provider directory at **Humana.com**. Under “Find a doctor,” choose “Search” to get started.

When submitting updates, healthcare providers are encouraged to provide their contact information in case there are questions about the correspondence.

Medical Records

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

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

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

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

To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine

disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of patient information.

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

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

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

Submitting Medical Records

Providers can submit medical records to Humana several ways:

- Humana’s Medical Records Management (MRM) application on the Availity Provider Portal at [Availity.com](https://www.availity.com)
- EMR vendor
- Fax to 866-305-6655
- Mail to:
Humana Medical Records Management
P.O. Box 14465
Lexington, KY 40512

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

Provider Claims Dispute Process

For All Products: If providers disagree with Humana’s payment denial or nonpayment of a claim, they can request a dispute/reopening of the issue by calling or writing to Humana using the contact information on the back of the patient’s Humana ID card. If the provider does not have this information, he/she can contact Humana at:

- Phone: 800-457-4708
- Address: Humana Correspondence
P.O. Box 14601
Lexington, KY 40512

When submitting a request for dispute/reopening in writing, providers should include all of the following information:

- Provider name
- Tax ID
- Member name and identification number
- Date of service

- Relationship of the member to the patient
- Claim number
- Charge amount
- Payment amount
- Proposed correct payment amount
- Difference between the amount paid and the proposed correct payment amount
- Brief description of the basis for the contestation request
- Relevant supporting documentation (medical records, copy of invoice, etc.).

Claims disputes must be received by Humana within 18 months of the date the claim was paid – unless state or federal law or the agreement require another time period – or the claim will not be reopened.

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

If the provider is unsatisfied with the outcome of the review, he/she can submit a request for a second dispute/reopening to HumanaProviderServices@humana.com. The Provider Concierge Unit reviews escalated issues when providers are unable to obtain resolution to disputes/reopenings via normal submission methods. Providers will need to include the same information that was submitted with the initial dispute along with any reference ID number provided during previous contact with Humana. The provider will receive an immediate auto-acknowledgement email advising that the communication was received. Within 72 hours, the provider will receive an email with a reference ID number that can be used when corresponding with the Provider Concierge Unit.

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

Member Grievance/Appeal Process

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

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

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

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

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

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

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

Humana will accept expedited/urgent appeals for Medicare Advantage members from the member, representative, or physician. An AOR is not required for a physician requesting an expedited/urgent appeal. The member's treating physician has the right to file a standard preservice appeal request on behalf of the member as long as the member is notified. An AOR is not required for MA plan members.

For commercial plan members, Humana will accept requests for expedited/urgent appeals from members and/or providers, including prescribing physicians. Please note that certain states and federal programs might have specific processes for physician grievance/appeal requests.

If the initial grievance/appeal is upheld, the resolution letter will provide next-level rights, as applicable.

Additional details regarding commercial and Medicare Advantage appeals on behalf of members are set forth below.

Commercial Appeals Definition of Terms

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

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

- Based on rescission of coverage

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

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

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

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

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

Commercial Appeals Process

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

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

Appeals may include:

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

Humana will identify and remove any communication barrier that might impede the member from effectively making appeals. Humana will facilitate the request to file an appeal for a member who has a communication

challenge affecting his/her ability to communicate or read through the following means:

- A TTY line for the hearing impaired
- A translation service for members unable to speak English if an in-house translator is not available
- Additional accommodations for any member with special needs who is unable to follow the standard process Humana will provide a full and fair review of the appeal. All appeal reviews will be conducted by a reviewer who:
 - Did not participate in the initial decision
 - Is not a subordinate of the individual who made the initial decision

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

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

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

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

Procedures for Additional Level for Commercial Appeals:

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

Medicare Appeals Definition of Terms

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

Expedited/Urgent Appeal: A verbal or written request for a fast review of a preservice denial, termination of care, or a reduction in the level of care. Expedited/urgent

appeals are applicable if the time frame for a standard appeal could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. They also are applicable for care or treatment that, if not rendered, could subject the member to severe pain that cannot be adequately managed, based on the opinion of a practitioner with knowledge of the member's medical condition. Expedited appeals exclude requests for payments for services already provided.

Independent Review Entity (IRE): An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to provide a review of a plan's appeal decision.

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

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

Medicare Appeals Process

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

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

- A TTY line for the hearing impaired
- A translation service or in-house translator for members unable to speak English
- Additional accommodations for any member with special needs who is unable to follow the standard process

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

Medicare Advantage Plans: Notification of the decision will be issued within the following time frames from

the date the request is received (with the exception of Medicare Part B drugs):

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

The time frames for Medicare Part B drugs are:

- Expedited – No later than 72 hours (no extensions permitted)
- Standard Preservice – No later than seven days (no extensions permitted)

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

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

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

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

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

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

Provider Termination and Appeal Process

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

Should a provider, Independent practice association (IPA) or physician-hospital organization (PHO) elect to terminate network participation, a notice of the pending termination must be forwarded to Humana in accordance with the terms of the agreement and applicable state and federal regulations.

Note 1: Humana has an established policy and procedures to notify members in advance of an impending termination of any provider. Advance notice is required by Humana

to comply with all federal and state laws, rules and regulations, and accreditation agencies regarding the notification to all members affected by the termination of a provider.

Note 2: Humana reviews the Department of Health and Human Services' (HHS) opt-out list, the CMS preclusion list, SAM list, and the OIG's sanction list as often as required by federal regulations. Should a provider's name appear on a current OIG/CMS excluded-provider listing, Humana will take immediate action to terminate the provider's network participation and, if applicable, take appropriate corrective actions. Other sanctions (e.g., loss of professional license) also are grounds for immediate termination.

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

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

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

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

Covered Services

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

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

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

Clinical and Behavioral Health Practice Guidelines

Humana provides web links to [clinical and behavioral health practice guidelines](#) developed by nationally recognized organizations. The guidelines are reviewed and updated accordingly.

Compliance/Ethics

Liability Insurance

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

Compliance and Fraud, Waste and Abuse Requirements

Contracted providers and those they employ and/or contract to support a contract with Humana are responsible for complying with all applicable laws, regulations and Humana's policies and procedures. Most notably, contracted providers must:

- Provide training on the separate topics of general compliance and combating fraud, waste and abuse (FWA) to all who support a plan administered by Humana
- Require the above to report suspected or detected noncompliance and FWA
- Offer and widely publicize a method to confidentially and anonymously make such a report
- Investigate suspected and detected noncompliance and FWA
- Take disciplinary action when applicable
- Notify Humana when suspected or detected noncompliance or FWA can or does impact Humana or any member of a plan administered by Humana

Additional information about the above and related requirements are outlined in [Humana's Compliance Policy and Standards of Conduct documents](#).

Contracted providers must assure those who provide services for Humana’s Medicare and/or Medicaid-eligible members, as well as those they employ or contract, comply with all requirements outlined in the above-referenced documents.

Note: Humana also makes a separate [guidance document](#) available online that provides answers to frequently asked questions about compliance program requirements.

Medicare

Medicare Marketing and communication Literature and Provider-sponsored Activities:

For purposes of this manual, the term “Medicare marketing and communication” includes any information, whether oral or written, intended

to promote or educate prospective or current Humana Medicare Advantage or prescription drug plan members about Humana or its Medicare plans, products or services. This includes, but is not limited to, any and all promotional materials used at provider-sponsored activities, such as open houses, health fairs and grand openings. Examples of promotional materials include letters, advertisements, invitations and announcements that use Humana’s name. Medicare marketing and communication must be approved through the Humana corporate review process prior to a provider conducting any Medicare marketing and communication activity. The Humana corporate review process includes review by legal and regulatory compliance and filing through Humana’s Medicare product compliance department and CMS (as applicable), in accordance with CMS guidelines.

To obtain approved Medicare marketing or communication materials or to arrange for a provider-sponsored activity, contact the Medicare sales director in your local Humana market office, sales and marketing support executive or physician marketing contact. Any joint (provider and plan) communication or marketing activity must also comply with Humana policies and procedures, as well as federal and state regulations. For applicable Humana policies, please see docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=1827514. Any misrepresentation of a Humana Medicare product or service, intentional or not, is a serious violation of Humana’s agreements with CMS.

Provider Affiliations: Providers can announce new or continuing affiliations for specific sponsors of Medicare Advantage or prescription drug plans through direct mail, email, telephone or advertisement using Humana-approved templates. Providers may not create their own communications for this purpose, or alter the templates in any way, unless approved through the Humana corporate

review process. Humana Marketpoint must review the communication prior to the provider sending it to ensure that it adheres to the approved template or that the communication has been approved through the Humana corporate review process. The announcement must clearly state that the provider also may contract with other plans/ Part D sponsors. Any affiliation materials that describe plan benefits, premiums or cost sharing must be approved by Humana and CMS prior to use and may not be mailed by providers, as these would be considered marketing materials for a plan.

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

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

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

A member cannot be disenrolled based on the member’s utilization (or lack of use) of services or because of mental or cognitive conditions (including mental illness and developmental disabilities), disagreement with a provider regarding treatment decisions, or as retaliation for a member’s complaint, appeal or grievance. Before initiating

a request to disenroll a member for cause, the provider and Humana must make a serious effort to resolve the problems, such as encouraging the member to change his/her behavior, and must document the result of this action. If the behavioral problems are not resolved, the provider may initiate a request to disenroll the member by submitting the Request for Disenrollment for Cause form to the local Humana market office. The form is available through the [local Humana market office](#).

CMS requires Humana to notify a Medicare member that the consequences of continued disruptive behavior could include disenrollment from the plan. **The health plan and provider must reasonably demonstrate that the member's behavior is not related to the use of prescribed medications, mental illness or cognitive conditions (including mental illness and developmental disabilities), treatment for a medical condition, or use (or lack of use) of the provider's medical services.**

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

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

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

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

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

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

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

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

Specific Medicare Advantage Plan Requirements: Providers must remain neutral when assisting with enrollment decisions.

Providers may not:

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

Providers may:

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from www.Medicare.gov), including in areas where care is delivered.
- Provide the names of plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the low-income subsidy.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefits information (these discussions may occur in areas where care is delivered).

- Make available, distribute and display communication materials, including in areas where care is being delivered.
- Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered, such as common entryways, vestibules, hospital or nursing home cafeterias and community, recreation or conference rooms.
- Refer patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, their state Medicaid office, local Social Security office, CMS' website (www.Medicare.gov) or 800-MEDICARE.

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

Summary of CMS Requirements	CFR42 (Section)
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hours a day, seven days week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in medical record if individual has executed advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1) administer and evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4) 422.504(f)(2)

Summary of CMS Requirements	CFR42 (Section)
Must make good faith effort to notify all affected members of the termination of a provider contract 30 calendar days before the termination by plan or provider	422.111(e)
Submit data and medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, quality improvement and medical management	422.202(b); 422.504(a)(5)
Disclose to CMS quality and performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Notify providers in writing for reason of denial, suspension and/or termination	422.202(d)(1)
Provide 60-day notice (terminating contract without cause)	422.202(d)(4)
Comply with federal laws and regulations including, but not limited to, federal criminal law, the False Claims Act (31 U.S.C. et Seq.) and the anti-kickback statute (section 1128B(b) of the act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

Product/Plan Overview

Health Maintenance Organization (HMO)

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

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

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

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

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

Note 3: The HMO PCP is responsible for arranging for care in his/her absence.

Note 4: The attending physician should be credentialed by Humana.

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

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

- Medical coverage 24 hours a day, seven days a week
- Urgent but non-emergent appointments within 24 hours, seven days a week

- Urgently needed services must be provided immediately for Medicare members
- Non-urgent but in-need-of-attention appointments within one week
- Routine and preventive care or well-child appointments within 30 days

In addition, Humana recommends the following standards for all providers:

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

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

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

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

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

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

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

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

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

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

1. Obtain documented acceptable evidence indicating the member has permanently moved out of the service area. Acceptable evidence includes:
 - Certified return-receipt letters, indicating an absence of more than six months.
 - Conversation documented and witnessed when a member admits to a permanent absence from the service area, but does not voluntarily choose to disenroll.
 - Medical records that indicate an absence of more than six months from the service area.
2. Complete a Request to Disenroll form (available from the local Humana market office) and attach any supporting documentation regarding the member's move outside the service area.
3. Send the form and documentation to the following address:

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

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

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

Preferred Provider Organization (PPO)

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

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

Credentialing

Credentialing is the process of obtaining and reviewing documentation to determine participation status in a health plan. The documentation may include, but is not limited to, the applicant's education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history and professional competence. Generally, the terms credentialing and recredentialing include the review of the information and documentation collected, as well as verification that the information is accurate and complete. The credentialing and recredentialing policies can be viewed here: <http://apps.humana.com/marketing/documents.asp?file=3527992>.

Council for Affordable Quality Healthcare: Humana is a member of the Council for Affordable Quality Healthcare (CAQH). CAQH is an online single-entry national database that eliminates the need for providers to complete and submit multiple credentialing applications. Physicians and other healthcare providers who are members of CAQH are able to submit an initial credentialing application to Humana and provide the required information at recredentialing rather than completing credentialing

applications. Additional information is available online at Humana.com/provider/medical-resources/join-humana-network/credentialing-caqh.

Please note that the aforementioned information is relative to participating providers only. Nonparticipating providers interested in joining our network should visit: Humana.com/provider/medical-resources/join-humana-network

Quality Management

Humana has a comprehensive quality improvement program that encompasses clinical care, preventive care, population health management and the health plan's administrative functions. To receive a written copy of Humana's quality improvement program and its progress toward goals, submit a request to the following address: Humana Quality Operations Compliance and Accreditation Department-QI Progress Report, 321 W. Main St., WFP 20, Louisville, KY 40202

Quality Management Activities: Participating providers agree to allow and assist Humana with its performance of the following quality management activities listed on Humana's [quality resources webpage](#), as well as the following:

- Occurrences and adverse events reporting – Unexpected quality of care occurrences and adverse events involving members are reported to the Quality Management Department through various sources, including providers, Risk Management, Humana clinical associates and claims-based reports. Cases are reviewed according to Humana's Quality Management and, as applicable, peer-review process, as required by law and accrediting agencies.
- CMS Quality Improvement Organization (QIO) – QIO oversees the Medicare Advantage Prescription Drug (MAPD) plans and collaborates with the plan for quality improvement activities.
- Member Grievances– Oral and written member grievances pertaining to quality-of-care may be referred to the Quality Management Department for review. Participating providers are required to participate as requested by Humana in review and remediation of such member quality-of-care grievances.

Medicare Advantage (MA) organizations must comply with the following requirements:

- Maintain a health information system that collects, integrates, analyzes and reports data necessary to implement the quality improvement program.

- Have a chronic care improvement program (CCIP) that identifies enrollees with multiple or severe chronic conditions who meet the criteria for participation, and a mechanism for monitoring enrollee participation in the program. Humana's CCIP focuses on effective management of members who have COPD (chronic obstructive pulmonary disease).

Population Health Management

Disease Management and Case Management Programs:

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

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

Case Management Programs

Complex case management (CCM) is provided by Humana nurses specially trained in case management. Their focus is on members with complex medical situations or those who have been hospitalized. Management varies by the individual and might include support on-site or by telephone, discharge follow-up support, coordination of services and integrated behavioral health assessment.

To refer commercial members, call 800-327-9496.

Medicare members can be referred to CCM and DM programs via the Health Service Line, 800-322-2758.

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

Information about Humana's health and wellness, disease management and case management programs, including how to refer members to the programs, is [here](#).

Humana At Home (HAH) is a Humana Inc. source for providing care management services to Medicare Advantage members identified as having complex

challenges, including multiple acute and chronic conditions, physical and behavioral health compromises, multiple comorbidities, frailty and disability, as well as cognitive, social, end-of-life issues, isolation, depression, polypharmacy challenges and financial issues. Services are delivered by telephone and/or in person. Practitioners and providers can make referrals by calling the HAH Care Center at 800-662-9508 during regular business hours or by calling the number on the back of the patient's Humana ID card.

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

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

ICM partners with members to:

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

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

- Go365™, an incentive-based wellness program, empowers people with the tools necessary to reach their optimal health. By participating in health-related activities that can be tracked and measured, such as taking wellness classes, exercising and getting regular medical check-ups and screenings, commercial members earn points that are used to determine their status. Members also earn a “buck” for every point earned, which they can redeem for products, services and discounts with our preferred partners. Go365 is available to commercial (fully insured, administrative- services only [ASO] [self-funded]) and Medicare (MA/MAPD and group) members.
- HumanaBeginnings®: Humana’s maternity management program may be available to commercial fully insured members, select ASO groups, Illinois duals and Medicare members. HumanaBeginnings (HB) provides a maternity program with prenatal services to eligible members through telephone outreach regardless of gestational age at time of enrollment. The primary focus, by telephone, is moderate- to high-risk members; however, low-risk members and catastrophic cases may participate in the letter campaign portion of the program. HB provides pregnant members with education, guidance and support to increase their understanding of healthcare options, risk factors and lifestyle changes, enhancing their ability to better manage their pregnancies and babies’ health for the best possible outcomes. Support is provided by registered nurses licensed in the state in which the member resides.

To refer a member, call 888-847-9960, email HumanaBeginnings@humana.com, or encourage the patient to call Humana at the number on the back of their Humana ID card and request a HumanaBeginnings nurse.

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

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

The program includes:

- Educating the member about the disease and its medical management
- Reinforcing the importance of the treating physician’s prescribed plan of care
- Addressing side effects of therapy to increase the member’s comfort
- Attempting to avoid hospitalizations

- Monitoring compliance with medications
- Helping transition from active treatment to recovery
- Supporting informed end-of-life decisions, when appropriate
- Comanagement with any other clinical program as necessary

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

Humana Chronic Condition Program: The Humana Chronic Condition Program offers support for members with:

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

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

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

- Post-discharge case management and follow-up with the parents/guardians for 30 days after hospitalization.
- Inpatient management for program participants who are readmitted within 30 days after a prior hospital discharge for treatment of a condition similar to that of the initial hospitalization.
- The NICU Grad program for up to the first year of life (for high-risk patients).

To refer a member, call 855-391-8655 and select Option 1, or email NICU@humana.com.

Renal Disease Program (Medicare/commercial): Renal care is a program that includes education and coordination with the PCP, nephrologists and/or other specialists, conducted by telephone by nephrology nurses who coordinate all aspects of patient care for hemo/peritoneal dialysis. For more information, visit our [Renal Disease Program](#) site on Humana.com.

Senior Case Management Program (SCM) (Medicare): SCM is for members who have chronic diseases or acute health concerns and need in-depth education.

The overall goal is to reduce readmissions.

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

Reasons for a referral may include:

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

Call 800-322-2758 to refer a member.

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

- Phone: 866-421-5663
- Fax: 502-508-9300
- Email: Transplant@humana.com

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

Humana identifies members who may be eligible for specific disease management programs. Patients who are identified by the physician/provider in the inpatient or outpatient setting as being candidates for any of the disease management programs can contact Humana Customer Service at the number on the back of the patient's Humana ID card for information on Humana's chronic care management programs. Please note the chronic care management or case management referral process above.

Humana EAP and Work-life Services

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

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

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

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

Contact us

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

Clinical services

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

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

Claims procedures

Humana does not reimburse for EAP appointments that were canceled by the member or those where the member failed to show for an appointment. Providers agree not to charge a member for missed sessions. EAP claims must be submitted on a Case Information Update Form (CIUF) on either the EAP Billing Form (included in the authorization notification packet) or a CMS 1500 form within 90 days

of the final EAP session to ensure prompt payment and avoid claim denial. The explanation of payment (EOP) or remittance advice will be mailed separately from any payment for claims once the claim is processed.

EAP claims and claims disputes should be mailed to:
Humana EAP and Work-life Services
2101 W. John Carpenter Freeway, Suite 150
Irving, TX 75063

Or faxed to 866-331-5673.

Note: Online billing is not available for EAP claims.

Rights and Responsibilities

Physicians'/Providers' Rights and Responsibilities

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

Physician/providers must:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which provider's services are regularly performed.
- Agree to comply with Humana's quality assurance, quality investigation and peer review process, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana.
- Be credentialed by Humana and meet all credentialing and recredentialing criteria as required.
- Not be on the HHS Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) or the General Service Administration's System of Award Management (SAM) debarment list.
- Not be on the CMS preclusion list.
- Provide documentation on their experience, background, training, ability, malpractice claims history, disciplinary actions or sanctions, and physical and mental health status for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable, and/or a state Controlled Dangerous Substance (CDS) certificate or license, if applicable.
- Have a current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Be a medical staff member in good standing with a participating network hospital(s) if he/she makes plan-member rounds and have no record of hospital privileges having been reduced, denied or limited, or if so, provide an explanation that is acceptable to the plan.
- Inform Humana in writing within 24 hours of any revocation or suspension of his/her Bureau of Narcotics and Dangerous Drugs number and/or of suspension, limitation or revocation of his/her license, reduction and/or denial of hospital privileges, certification, CLIA certificate or other legal credential authorizing him/her to practice in any state in which the provider is licensed.
- Inform Humana immediately of changes in licensure status, tax identification numbers, NPI, telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance below the required limits and any other change which would affect his/ her participation status with Humana.
- Not discriminate against members as a result of their participation as members, their source of payment, age, race, color, national origin, religion, sex, sexual preference, health status or disability.
- Not discriminate in any manner between Humana members and non-Humana members.
- Inform members regarding follow-up care or provide training in self-care.
- Assure the availability of physician services to members 24 hours a day, seven days a week (required for HMO PCPs and all MA providers).
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana physician (required for HMO PCPs and all MA providers).
- Refer Humana members with problems outside of the physician's normal scope of practice for consultation and/or care to appropriate specialists contracted with Humana on a timely basis, except when participating providers are not reasonably available or in an emergency.
- Refer members only to participating providers, except in an emergency.
- Admit members only to participating network hospitals, SNFs and other facilities and work with hospital-based physicians at participating hospitals or facilities in cases of need for acute hospital care, except when participating providers or facilities are not reasonably available or in an emergency.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Humana member, subscriber, or enrollee other than for copayments, deductibles, coinsurance, other fees that are the member's responsibility under the terms of their benefit

plan, or fees for noncovered services furnished on a fee-for-service basis. Non-covered services are services not covered by Medicare, or services excluded in the member's plan.

- Provide services in a culturally competent manner (i.e., removing all language barriers; arranging and paying for interpretation services for limited English proficient [LEP] and the hearing/visually impaired) as required by state and federal law. Care and services should accommodate the special needs of ethnic, cultural and social circumstances of the patient. Additional information and resources are made available by the U.S. Department of Health and Human Services, Office of Minority Health at the following webpages:
 - <http://minorityhealth.hhs.gov>
 - <https://thinkculturalhealth.hhs.gov/>
- Provide access to healthcare benefits for all plan members in a manner consistent with CMS requirements for any Humana Medicare Advantage member.
- For Medicare Advantage members who have end-stage renal disease (ESRD), complete the Chronic Renal Disease Medical Evidence Report, which is provided by the Social Security office when the provider becomes aware of the disease. The form must be completed and returned to the Social Security office and the ESRD Network. Fax the form to 502-508-3450 or mail to:
Humana
Attn: Medicare Reconciliation Department – ESRD Unit
Waterside Building
101 E. Main St.
Louisville, KY 40202
- Provide or arrange for continued treatment to all members including, but not limited to, medication therapy, upon expiration or termination of the agreement.
- Help guarantee accessibility of services to members by maintaining a ratio of members to full-time equivalent (FTE) physicians as follows:
 - One physician FTE to 2,400 commercial and Medicare Advantage member equivalents (CMMEs). An MA member counts as three member equivalents; a commercial member counts as one member equivalent.
 - A non-physician practitioner (PA, ARNP, etc.) counts as half (.5) a physician FTE for MA and commercial members.
 - One physician FTE for 1,500 Medicaid members.
 - A non-physician practitioner (PA, ARNP, etc.) counts as one-third (.33) physician FTE for Medicaid and may serve no more than 500 Medicaid members.

Note: Full-time equivalents may vary by markets. Contact the local Humana market office.

- Retain all agreements, books, documents, papers and medical records related to the provision of services to members as required by state and federal laws and in accordance with relevant Humana policies.
 - Treat all member records and information confidentially and not release such information without the written consent of the member, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
 - Upon request of Humana, provide an electronic, automated means, at no cost, for Humana and all Humana-affiliated vendors acting on behalf of Humana to access member clinical information including, but not limited to, medical records, for all payer responsibilities including, but not limited to, case management, utilization management, claims review and audit and claims adjudication.
 - Transfer copies of medical records for the purpose of continuity of care to other Humana providers upon request and at no charge to Humana, the member or the requesting party, unless otherwise agreed upon.
 - Provide copies of, access to and the opportunity for Humana or its designee to examine the provider's office books, records and operations of any related organization or entity involving transactions related to health services provided to members. A related organization or entity is defined as having:
 - Influence, ownership, or control and:
 - Either a financial relationship or a relationship for rendering services to the primary care office.
- The purpose of this access is to help guarantee compliance with all financial, operational, quality assurance and peer review obligations, as well as any other provider obligations stated in the agreement or in this manual. Failure by any person or entity involved, including the provider, to comply with any requests for access within 10 business days of receipt of notification will be considered a breach of contract. For records related to Humana MA enrollees, this access right is for the time stipulated in the agreement or the time period since the last audit, whichever is greater.
- To the extent applicable to the physician, assume full responsibility to the extent of the law when supervising/sponsoring, whether through a protocol, collaborative, or some other type of agreement, physician assistants (PAs), advanced practice registered nurses (APRNs), nurse practitioners (NPs) and all other healthcare

professionals required to be supervised or sponsored, whether through a protocol, collaborative or some other type of agreement under applicable federal and state law in order to treat members.

- Submit a report of an encounter for each visit when the member is seen by the provider, if the member receives a HEDIS service. Encounters should be submitted electronically or recorded on a CMS-1500 Claim Form and submitted according to the time frame listed in the agreement.
- Meet the requirements of all applicable state and federal laws and regulations, including Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.
- Perform services under the agreement consistent and in compliance with Humana's contractual obligations under its Medicare Advantage contract(s). Physician agrees to cooperate with and assist Humana in its efforts to comply with its Medicare Advantage contract(s) and/or Medicare Advantage rules and regulations and to assist Humana in complying with corrective action plans necessary for Humana to comply with such rules and regulations.
- Submit complete member referral information when applicable and in a timely manner to Humana via electronic means or telephone.
- Notify Humana of scheduled surgeries/procedures requiring inpatient hospitalization.
- Notify Humana of any material change in provider's performance of delegated functions, if applicable.
- Notify Humana of his/her termination 60 days prior to the effective date of termination.
- Not be excluded from participating in Medicare.
- Cooperate with an independent review organization's activities pertaining to the provision of services for commercial members, Medicare enrollees in an MA plan and Medicaid members. Respond expeditiously to Humana's requests for medical records or any other documents to comply with regulatory requirements and to provide any additional information about a case in which a member has filed a grievance or appeal.
- Abide by the rules and regulations and all other lawful standards and policies of the Humana plan(s) with which the provider is contracted, including Humana's.
- Adhere to [**Ethics Every Day for Contracted Healthcare Providers and Business Partners**](#).
- Understand and agree that nothing contained in the agreement or this manual is intended to interfere with or hinder communications between providers and members regarding a member's medical condition

or available treatment options or to dictate medical judgment.

- For providers who participate in MA networks and who participate in Original Medicare, abide by the guidelines set out in Humana's Rules of Participation for MA Networks, which are [available here](#). A paper copy can be obtained upon request.
- For providers who have downstream agreement(s) with physicians or other providers who provide services to Humana members, agree to provide a copy of said agreement(s) to Humana upon request (financial information is not requested).
- Abide by all state and federal laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information.
- Submit a claim on behalf of the member in accordance with timely filing laws, rules, regulations and policies.
- Agree to pay court costs and/or legal fees incurred by Humana or the member to enforce the terms of this provision.
- Understand and agree that provider performance data can be used by Humana.
- Not require members to select and pay for any type of "concierge medicine" program to receive services, items and/or benefits covered by the applicable Humana plan from the provider. Humana considers concierge medicine programs to include any practice management model under which a provider charges each patient a monthly, annual or other periodic fee in exchange for enhanced practice services over and above those services that are covered under the member's health benefit plan, or charges such a fee before agreeing to provide any medical services to a patient.

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

- The provider accepts Humana's reimbursement as payment in full for all services that are covered services under the member's health benefit plan and the provider is prohibited from holding plan members liable for the payment of such services, except for member cost-sharing authorized under the plan.
- Any fees paid by members for the provider's concierge medicine program cannot be in exchange for services that are covered services under the member's health benefit plan.
- The provider must be accessible and available to members consistent with Humana's participating provider requirements including, but not limited to, those requirements outlined in this manual, the provider's participation agreement with Humana

and those requirements outlined by any applicable state or federal law, including but not limited to those requirements outlined by the Centers for Medicare & Medicaid Services under the Medicare Managed Care Manual MMCM, Ch. 4, Section 110.1.1, regardless of whether a member chooses to participate in the provider's concierge medicine program. The provider shall ensure that quality of care will not be adversely impacted if a member chooses not to participate in the provider's concierge medicine program.

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

Members' Rights and Responsibilities

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

Humana members have the right to:

- Be provided with information about their plan, its services and benefits, its providers and the rights and responsibilities of members.
- Choose a primary care provider from our network of affiliated providers and to change to another primary care provider in the Humana network.
- Discuss their medical record with their physician and receive, upon request, a copy of that record.
- Participate with providers in making decisions about their healthcare.
- Have a candid discussion with their provider about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Expect reasonable access to medically necessary healthcare services, regardless of gender, race, national origin, religion, physical abilities or source payment.
- File a formal complaint, as outlined in the plan's grievance procedure, and expect a response to that complaint within a reasonable period of time.
- Be treated with courtesy and respect, with appreciation for their dignity and protection of their right to privacy.
- Make recommendations regarding the plan's "rights and responsibilities" policies.
- Expect Humana to adhere to all privacy and confidentiality policies and procedures.
- Have an initial health risk assessment conducted for care (for MA members) within the first 90 days of enrollment.
- Have direct access (for MA members) to a woman's health specialist, within the network, for routine and preventive health services, such as mammography screening and influenza vaccinations, that are provided as basic benefits for women.
- Have direct access (for MA members) to influenza vaccinations for routine and preventive health services provided as basic benefits. Certain preventive health services, such as influenza and pneumococcal vaccines, do not require a copayment.
- Receive services that are provided in a culturally competent manner.
- Receive treatment for any emergency medical condition.
- Select an in-network provider and not be balance billed for medically necessary covered services.
- Receive an EOB and discuss that EOB with the plan.
- File a claim or have a claim filed by a provider on their behalf.
- Request and receive an organization determination from the plan regarding the services or treatment being requested, in the event that MA members disagree with their physician about a denial of service.

Humana members have the responsibility to:

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

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

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

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

The member's primary care office is not required to have living will or durable power of attorney blank forms available. However, the primary care office must have

procedures in place to help assure that the existence of completed advance directive forms is conspicuously noted in the member's medical record.

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

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

Accreditation

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

National Committee for Quality Assurance (NCQA):

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

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

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

the examination. The type of outreach the member receives is based upon consumer insights and history of completing a dilated eye examination.

Periodically, the health plan quality management department may visit provider offices to review medical records of members and to collect data.

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

Delegation

What is Delegation?

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

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

A function may be fully or partially delegated. Full delegation allows all activities of a function to be delegated. With partial delegation, only some of the activities associated with a particular function will be delegated. For example, partial delegation of utilization management might mean that referral management is delegated, while Humana retains the utilization management of inpatient services for members. The decision of which functions may be considered for delegation is determined by the type of contract a delegate has with Humana/ChoiceCare/HBHN, as well as the ability of the delegate to perform the function pursuant to Humana's policies and procedures. The decision also is

determined by accreditation organization standards, state/federal regulatory requirements, and whether the delegate accepts the required oversight of the function by Humana.

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

Contact the local Humana market office provider representative for detailed information on delegation.

State-specific Provisions

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