Physician/Facility FAQ

Humana's Medicare Advantage (MA)

Preferred Provider Organization (PPO)

HumanaChoice® PPO (Individual Plan)

Humana created a collection of questions and answers for healthcare providers. They are divided into three sections:

- General questions
- Reimbursement questions
- Operational guidelines

Humana

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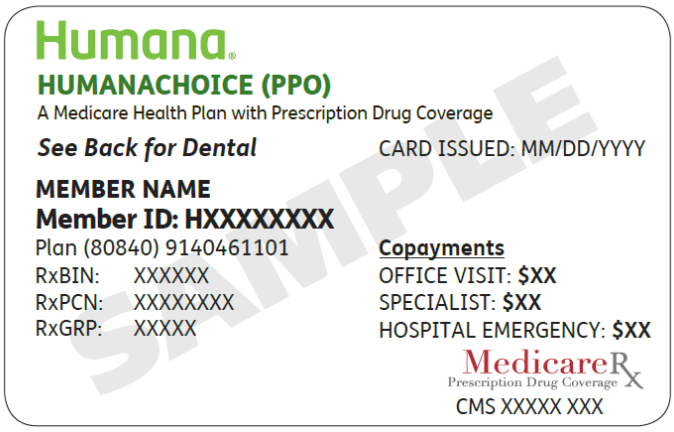
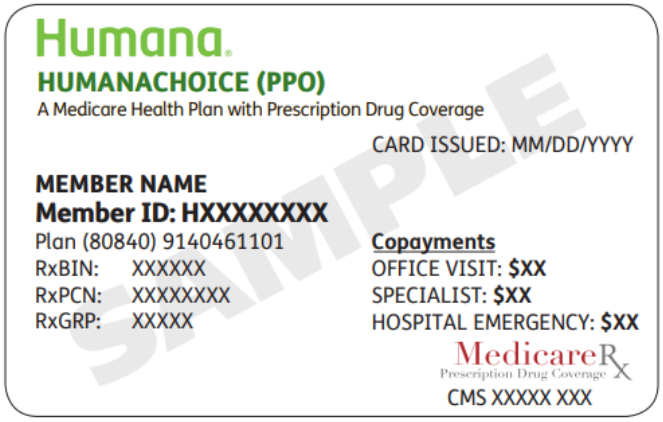
Reminders for 2022

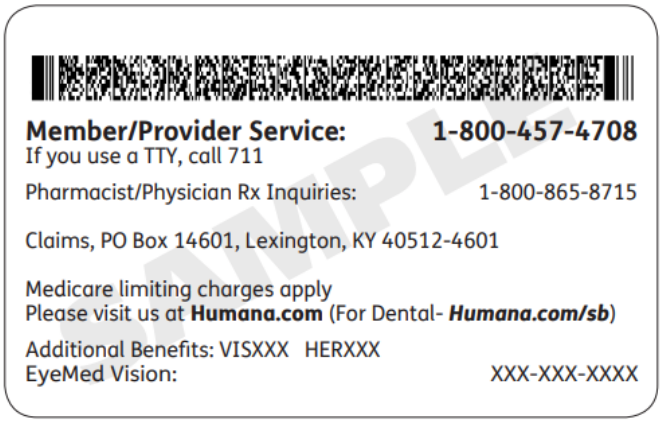
- Patients with Humana PPO plans are not required to select a primary physician.
- Any Humana MA PPO participating healthcare provider can see a patient with a HumanaChoice PPO plan as an in-network provider.
- Healthcare providers do not need a referral to see patients with a HumanaChoice PPO plan.
- Patients with HumanaChoice PPO plans can see any Medicare healthcare provider.

Individual MAPD PPO



Individual MAPD PPO No Dental





General questions

Q: How are contracted healthcare providers reimbursed?

A: Reimbursement is based on the contracted rate, which typically is a percentage of the Original Medicare rate. For details, healthcare providers should check Humana claims payment policies at Humana.com/Providers (unsecure) and their contracts.

Q: How are noncontracted healthcare providers reimbursed?

A: Noncontracted healthcare providers are reimbursed according to Original Medicare's fee schedule for the area.

Q: Are National Provider Identifiers (NPIs) required on claims submitted to Humana?

A: Yes. NPIs, as well as taxonomy numbers and Tax Identification Numbers, are required to price and process claims appropriately. Facilities should use subunit identifiers with their facility ID when submitting claims.

Q: If a patient disenrolls from a Humana MA PPO plan and returns to Original Medicare, how are the patient's cost shares calculated?

A: If a patient disenrolls from the Humana MA PPO plan and returns to Original Medicare, then Original Medicare cost-sharing provisions would apply.

Q: If a patient disenrolls from Humana's MA PPO plan and joins a different MA plan, how are the patient's cost shares calculated?

A: If a patient enrolls in a different MA plan, the copayments and deductibles specified in the patient's Summary of Benefits for the new MA plan would apply.

Q: Are there contracted labs?

A: Yes. There are contracted labs under this plan. The labs vary by market. Please refer to the provider directory for the appropriate market. The directory can be found at Humana.com/FindADoctor.

Q: Can healthcare providers go online to review their claim status or to verify patient eligibility?

A: Yes. Healthcare providers who want to review claims or verify eligibility for patients covered by Humana MA PPO plans can do so at Availity.com. Registration is required. Providers also can call Humana provider relations at **800-626-2741** for assistance.

Q: What recourse do healthcare providers have if they wish to dispute a payment?

A: The payment dispute process is included in the Humana Provider Agreement. For more information, refer to the Humana Provider Manual or view our presentation titled Claim Disputes and Corrected Claims.

Q: Can healthcare providers correct claims or provide additional claim information online?

A: Yes. Healthcare providers who have filed claims electronically can sign in to Availity.com and send batch claims or submit a corrected claim using the claim submission application.

Q: What format is required for claims?

A: Use the same format used for Original Medicare. Humana's MA PPO plans accept paper and electronic claims in 837I (Institutional) or 837P (Professional) format.

To decrease administrative costs and improve cash flow, clinicians and facilities are encouraged to use electronic claims submission whenever possible. When it is necessary to submit paper claims, please use the address below. Keep in mind, however, that the claim or encounter mailing address on the patient's Humana member ID card is always the most appropriate to use.

Humana MA PPO
c/o Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Q: Does Humana's MA PPO plan require advance patient notification for services that might not be covered under the MA PPO plan?

A: Regardless of whether Humana requires prior authorization for a particular item or service, when the healthcare provider thinks a service might not be covered, he or she should contact the plan for a formal determination of coverage.

If a network provider performs a service that might not be covered, and the plan has not issued a CMS-10003 Notice of Denial of Medical Coverage (or Payment), also known as the Integrated Denial Notice, a determination that the service isn't covered, the provider can collect only the cost sharing that would apply for the service as if the service were coverable. That is, the provider must not balance-bill an MA PPO-covered patient for a noncovered service if the plan has not issued the patient a formal CMS-10003 determination that the service will not be covered.

For more information, see Chapter 4, Section 160, of the Medicare Managed Care Manual.

Q: What does PPO SNP mean on the patient's ID card?

A: The addition of SNP means the patient is enrolled in a Special Needs Plan. It is a PPO plan with extra benefits for people with special healthcare needs. Benefit and eligibility information is available at Availity.com (registration required). Healthcare providers also can call the member/provider service number on the back of the patient's Humana ID card.

SNP training is required for any provider who sees a Humana MA plan member covered by any of our Special Needs Plans.

Please note: Federal law prohibits balance-billing of cost share-protected patients.

Compliance training and additional information is available at Humana.com/ProviderCompliance.

Reimbursement questions

Q: How are payments for inpatient hospital services determined?

A: The allowable amount for inpatient hospital services is based on contracted rates. These rates typically are a percentage of the Medicare Severity-Diagnostic Related Group (MS-DRG) payment system, less certain MS-DRG components that HumanaChoice PPO might not pay. See the applicable contract for each facility for details.

Q: How are payments for outpatient hospital services determined?

A: The allowable amount for outpatient hospital services is based on contracted rates. These rates typically are a percentage of Original Medicare's Ambulatory Payment Classification (APC) payment amount, less certain APC components that Humana might not pay. In addition, Humana's MA PPO has turned off many of the outpatient code edits that Medicare applies to the claim.

Q: Teaching hospitals receive an extra payment from Medicare. Does Humana's MA PPO pay the teaching hospitals this extra payment as well?

A: No. Humana's MA PPO does not make this extra payment to teaching hospitals. The Centers for Medicare & Medicaid Services (CMS) has carved out operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) from the payment to MA organizations. Medicare pays these add-ons to providers directly through its CMS Medicare Administrative Contractors (MAC) for Parts A and B or Durable Medical Equipment MAC.

Q: Under Original Medicare, hospital patients must fill out a Medicare Secondary Payer (MSP) questionnaire. Are hospitals required to implement this process for patients with Humana MA PPO plans?

A: No. CMS does not require MSPs for patients with MA. However, hospitals should have their patients fill out the MSP questionnaire. Humana reimburses healthcare providers and attempts to recover money from any third party that might be liable after the fact.

Q: What is an "essential hospital?"

A: The Medicare Modernization Act (MMA) includes provisions designed to increase beneficiary hospital choice in rural areas by providing structure and incentives that will broaden health plan service areas. The designation "essential hospital" is given to a hospital by the regional PPO and approved by CMS. If your hospital has been notified by CMS that it is designated as an "essential hospital" and you have further questions, please contact Humana's provider relations department at **800-626-2741**.

Q: How are rural providers, such as rural health clinics (RHCs) and critical access hospitals (CAHs), reimbursed?

A: Medicare reimburses rural providers using a methodology other than the Prospective Payment System (PPS) standard for Medicare, and we take this into consideration during contract negotiations.

A copy of the MAC for Parts A and B letter outlining your current interim rates typically is needed for negotiating your provider agreement. For nonparticipating providers, a copy of your MAC letter is mandatory for Humana to reimburse your claims appropriately.

Please contact Humana's provider relations department at **800-626-2741** for directions on providing that document to us.

Operational guidelines

Q: Does Humana's MA PPO follow Medicare guidelines promulgated in national coverage determinations (NCDs) and local coverage determinations (LCDs)?

A: Yes. Humana applies NCDs and LCDs in accordance with federal regulation and CMS guidance.

Q: Does Humana's MA PPO follow all Medicare rules for readmissions?

A: Yes. Humana's MA PPO follows all Medicare rules for readmissions.

Q: What are the enrollment and disenrollment guidelines?

A: Enrollment and disenrollment guidelines are determined by CMS. Please visit the CMS website at CMS.gov for more information.

Q: Can hospitals collect copayment amounts up front?

A: Yes. Hospitals can request the copayment up front and/or at the time of discharge.

Q: Are case management services available for Medicare Advantage PPO products??

A: Telephonic case management is available to Medicare Advantage HMO, PPO and PFFS Plans. Case Management programs and how to refer members to the programs can be found at Humana.com/provider or in the Provider Manual.

Q: What kind of criteria does Humana's MA PPO use for medical necessity?

A: Humana's MA PPO plans use Medicare coverage guidelines, nationally accepted guidelines (such as MCG) and peer-reviewed literature to determine medical necessity.

Q: What is Humana's involvement in discharge planning?

A: Humana's case managers work with facility discharge planners to create, implement and follow up on discharge plans. In addition, Humana collaborates on and facilitates discharge planning with the patient and/or the patient's representative and physician.

Q: Where can I find a list of services requiring preauthorization?

A: The full list of preauthorization requirements applies to Humana MA PPO-covered patients. Preauthorization is required for in-network inpatient admissions (except urgent or emergent) and some outpatient procedures the preauthorization and notification list is located at Humana.com/PAL.

Preauthorization requests for medical services may be initiated:

- Online at Availity.com (registration required)
- By calling Humana's interactive voice response (IVR) line at **800-523-0023**.

Q: Does Humana's MA PPO require hospitals to give the CMS "Important Message from Medicare" to all inpatient Medicare patients at time of admission?

A: Yes. CMS has ruled that hospitals must notify Original Medicare and MA beneficiaries who are inpatients about their hospital discharge rights. The regulation requires that hospitals provide and explain to all MA beneficiaries the standardized notice titled "Important Message" (IM) within two calendar days of admission and obtain the signature of the beneficiary or the beneficiary's representative. The signed copy can be stored electronically and must contain the following:

- Right to benefits for inpatient and post- hospital services
- Right to request immediate review of the discharge decision and access to other appeal processes if the beneficiary does not meet the deadline for immediate review
- Liability for charges for continued stay
- Right to receive additional information

A follow-up copy of the signed IM must be delivered by the hospital to the beneficiary or the beneficiary's representative not more than two calendar days before discharge. The follow-up notice is not required if the original IM is delivered within two calendar days of discharge. The physician who is responsible for the inpatient care must concur with the discharge.

Q: What do I need to do if my question is not listed here?

A: Contact Humana's provider relations department at **800-626-2741** or your Humana provider contractor.