Physician/Facility FAQ

Humana's Medicare Advantage (MA)

Health Maintenance Organization (HMO)

- Humana Gold Plus® HMO (Individual Plan)
- Humana Gold Plus® HMOPOS (Individual Plan)
- Humana Gold Plus® HMO SNP (Individual Plan)

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

- General questions
- Reimbursement questions
- Operational guidelines

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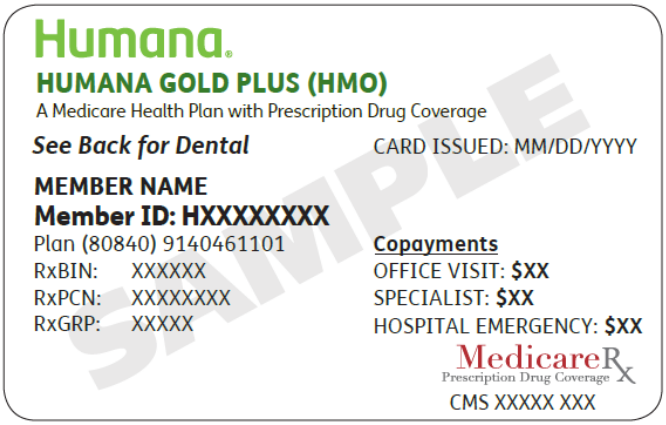
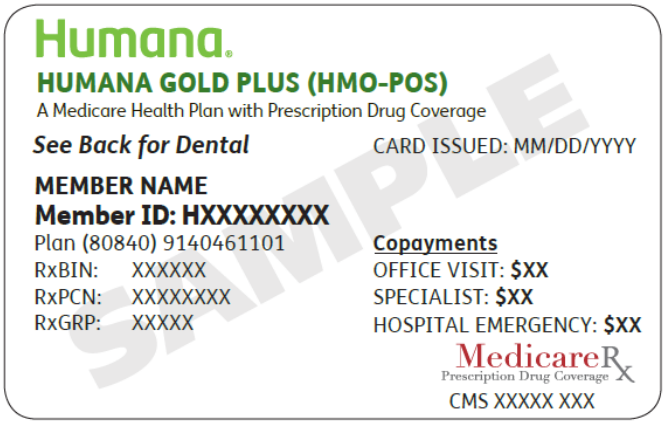
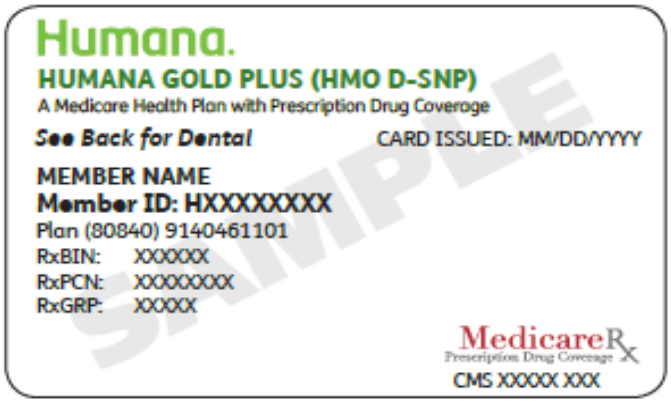
ID card samples







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 their contract and view Humana claims payment policies at Humana.com/Provider (unsecure).

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, taxonomy numbers and Tax Identification Numbers (TINs), are required to price and process claims appropriately. Facilities should use subunit identifiers with their facility IDs when submitting claims.

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

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

Q: If a patient disenrolls from Humana's MA HMO 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 apply.

Q: Are there contracted labs under HMO MA plans?
A: Yes. The labs vary by market. Please refer to our provider directory, Humana.com/FindADoctor, for the relevant market.

Q: What format is required for claims?

A: Use the same format as for Original Medicare. Humana's MA HMO 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 ID card is always the most appropriate to use.

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

Q: What are Humana's MA HMO referral requirements?

A: Humana MA HMO plans typically require referrals; however, these requirements can vary depending on the service(s) to be rendered, primary care physician assignment and geography. Healthcare providers should contact their market representative for an explanation of referral requirements in their area.

Q: What does HMO POS mean on the patient's ID card?

A: The addition of POS means that the patient is in a traditional HMO point-of-service plan and has some out-of-network benefits. Benefit and eligibility information is available at Availity.com. (Registration is required.) Healthcare providers also can call the member/provider service phone number listed on the back of the patient's Humana ID card.

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

A: It means the patient is enrolled in a Special Needs Plan, a type of HMO plan with extra benefits designed for people with special healthcare needs. Benefit and eligibility information is available at Availity.com. (Registration is required.) Healthcare providers also can call the member/provider service phone number listed 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..

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

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

A: Yes. Healthcare providers who want to review claims or verify eligibility for their Humana MA HMO-covered patients can do so at Availity.com. (Registration is required.)

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, please refer to the Humana Provider Manual or view our presentation titled Claims Disputes and Corrected Claims.

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

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

Q: Does Humana's MA HMO plan require advance patient notification for services that might not be covered under the MA HMO 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 is not covered, the provider can collect only the cost- sharing that would apply for the service as if the service were covered. That is, the provider must not balance-bill an MA HMO patient for a noncovered service if the plan has not issued the patient a formal, written determination that the service will not be covered.

For more information, refer to Chapter 4, Section 160, of the Medicare Managed Care Manual. Providers also can call Humana provider relations for assistance at **800-626-2741**.

Reimbursement questions

Q: How are payments for inpatient hospital services determined?

A: The allowable amount for inpatient hospital services is based on contracted rates. Healthcare providers should check their contracts or contact a provider contracting representative. They also can call **800-626-2741**.

Q: How are payments for outpatient hospital services determined?

A: The allowable amount for outpatient hospital services is based on contracted rates. Healthcare providers should check their contracts or contact a provider contracting representative. They also can call **800-626-2741**.

Q: Teaching hospitals receive added compensation from Medicare, such as operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME). Does Humana's MA HMO pay the same?

A: IME and DGME are reimbursed by the Medicare Administrative Contractor (MAC) on behalf of patients with MA plans via the cost report. As a result, Humana is not responsible for these components.

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 HMO plans?

A: No. The Centers for Medicare & Medicaid Services (CMS) does not require MSPs for patients with MA.

However, hospitals should ask patients with a Humana MA to fill out the MSP questionnaire to identify the appropriate payer. Humana reimburses healthcare providers and may attempt to recover money from any third party that might be liable. Humana MA members are required to provide this information to Humana.

Operational guidelines

Q: Does Humana's MA HMO follow Medicare guidelines promulgated by 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: What are the enrollment and disenrollment guidelines?

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

Q: Does Humana's MA HMO require hospitals to give the CMS "Important Message from Medicare" to all inpatient Medicare patients?

A: Yes. CMS has ruled that hospitals must notify Original Medicare and MA beneficiaries who are inpatients about their hospital discharge rights. Upon admission, the regulation requires that hospitals provide and explain to all MA enrollees 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 may be stored electronically and must contain:

- Right to benefits for inpatient services and for post-hospital services
- Right to request immediate review of the discharge decision and the availability of 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 days before discharge. The follow-up notice is not required if the original IM is delivered within two calendar days of discharge. The physician responsible for the inpatient care must concur with the discharge.

Q: Does Humana have on-site reviewers for acute inpatient admissions?

A: On-site nurses are available in some facilities in some markets. Check with the local market office to determine which facilities have on-site nurse reviewers.

Q: Does Humana's MA HMO plan offer case management services?

A: Case management services are available to members with some chronic conditions.

Information about Humana's Health and Wellness, Disease Management and Case Management programs and how to refer members to the programs can be found at Humana.com/Provider or in the Provider Manual.

Q: Does Humana's MA HMO do discharge planning?

A: Humana case managers work with facility discharge planners to facilitate and follow up on discharge plans with the patient and/or member representative and healthcare provider.

Q: Can hospitals collect copayment amounts up front?

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

Q: Are preauthorization and notification required?

A: The full list of preauthorization requirements, at Humana.com/PAL, applies to patients with MA HMO and HMO POS coverage. Preauthorization is required for in-network inpatient admissions (except urgent or emergent) and some outpatient procedures.

Preauthorization requests for medical services can be initiated:

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

Q: What guidelines do Humana's MA HMO plans use for medical necessity coverage determinations?

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

Q: Does Humana have on-site associates who present letters to doctors and patients explaining the appeal process?

A: Because Humana has a limited number of on-site associates to deliver letters, please coordinate with hospital employees for delivery of appeal rights letters for patients.

Q: What do I need to do if I have a question that isn't listed here?

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