

Physician FAQ

Humana's Medicare Advantage (MA)

Full Network and
Partial Network
Private Fee-for-service
(PFFS)

Humana Gold Choice® (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

Member eligibility can be verified through the Availity Provider Portal at [Availity.com](https://www.availity.com) (registration required). Eligibility also can be verified by calling Humana's Customer Care number, which is on the back of the patient's Humana ID card.

Humana



Humana private fee-for-service (PFFS) member identification card information

Humana.
HUMANA GOLD CHOICE (PFFS)
A Medicare Health Plan with Prescription Drug Coverage

CARD ISSUED: MM/DD/YYYY

MEMBER NAME
Member ID: HXXXXXXXXX
Plan (80840) 9140461101
RxBIN: XXXXXX
RxPCN: XXXXXXXX
RxGRP: XXXXX

Copayments
OFFICE VISIT: \$XX
SPECIALIST: \$XX
HOSPITAL EMERGENCY: \$XX

Network: Full

MedicareRx
Prescription Drug Coverage
CMS XXXXX XXX



Member/Provider Service: 1-800-457-4708
If you use a TTY, call 711

For Payment Terms and Conditions: 1-866-291-9714
Pharmacist/Physician Rx Inquiries: 1-800-865-8715
PROVIDERS: DO NOT BILL MEDICARE.
Claims, PO Box 14601, Lexington, KY 40512-4601
Medicare limiting charges apply
Please visit us at Humana.com (For Dentists- Humana.com/sb)

Additional Benefits: DENXXX VISXXX HERXXX
EyeMed Vision: XXX-XXX-XXXX

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Additional Benefits: DENXXX VISXXX HERXXX
EyeMed Vision: XXX-XXX-XXXX

Network: Full

The Humana-covered patient who has this ID card is in a fully networked PFFS plan with both in-network and out-of-network PFFS benefits.

Reimbursement for the Humana-contracted healthcare provider is governed by the provider's contract.

Reimbursement for the noncontracted provider is governed by Humana's PFFS Terms and Conditions. To see them, go to Humana.com/provider > Medical Resources > Medicare & Medicaid > Medicare Advantage Materials and click on "Medicare Advantage PFFS plan model terms and conditions of payment."

Network: Partial

The Humana-covered patient who has this ID card is in a partially networked PFFS plan and might have both in-network and out-of-network PFFS benefits for certain services, such as home health, laboratory, durable medical equipment (DME) and diabetic monitoring supplies from a DME provider.

Reimbursement for the Humana-contracted healthcare provider is governed by the provider's contract.

Non-network home health, laboratory and DME providers, and all other healthcare provider services, will be processed at the non-network PFFS plan rate, with reimbursement governed by Humana's PFFS Terms and Conditions. To see them, go to Humana.com/provider > Medical Resources > Medicare & Medicaid > Medicare Advantage Materials and click on "Medicare Advantage PFFS plan model terms and conditions of payment."

General questions

Q: How are contracted network PFFS 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 review Humana claims payment policies at www.Humana.com/provider (unsecure), and their contracts.

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: How are noncontracted healthcare providers reimbursed?

A: Noncontracted physicians are reimbursed according to Humana's PFFS Terms and Conditions.

Q: What happens if a patient disenrolls from a Humana Medicare Advantage PFFS plan and goes back to Original Medicare? How are the patient's cost shares calculated?

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

Q: What happens if a patient disenrolls from Humana's MA PFFS plan and joins a different 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: 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 [Claims Disputes and Corrected Claims](#).

Q: What format is required for claims?

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

(Professional) format. If the healthcare provider's office currently submits claims electronically to Humana, it can submit Humana's MA PFFS claims using the same process.

Submit paper claims to:

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

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. You can find the provider directory online at Availity.com or Humana.com/FindAProvider.

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 PFFS patients can do so at Availity.com (registration required.) Providers also can call Humana provider relations at **800-626-2741** for assistance.

Q: Do Humana's MA Full Network PFFS and Partial Network PFFS require advance coverage notification for services that might not be covered under the MA Full Network PFFS and Partial Network PFFS plans?

A: Yes. When the healthcare provider believes 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 if the service were actually coverable. That is, the provider must not balance bill a patient with an MA Full Network PFFS or Partial Network PFFS plan 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, refer to [Chapter 4, Section 160, of the Medicare Managed Care Manual](#).

Reimbursement questions

Q: How are payments for full-network inpatient hospital services determined?

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

Q: How are payments for full-network outpatient hospital services determined?

A: The allowable amount for outpatient hospital services is based on contracted rates. These rates are typically 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 Full Network PFFS has turned off many of the outpatient code editor edits that Medicare applies to the claim.

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

A: No. Humana's MA Full Network PFFS plan 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 Medicare Advantage organizations. Medicare pays these add-ons to providers directly through its CMS contractors (Medicare Administrative Contractor for Parts A and B [MAC] or Durable Medical Equipment Medicare Administrative Contractor [DME 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 Network PFFS plans?

A: No, CMS does not require MSPs for patients with Medicare Advantage. Humana reimburses physicians and other healthcare providers and attempts to recover money from any third party that might be liable.

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

A: The amount is determined by the provider's contracted rates. Medicare reimburses rural providers using a methodology other than the Prospective Payment System standard for Medicare, and Humana takes this into consideration during contract negotiations. A copy of the Medicare Administrative Contractor (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 Humana.

Operational guidelines

Q: Does Humana’s MA Full Network PFFS plan 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: 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: Are case management services available for Medicare Advantage network PFFS products? Are they on site?

A: On-site nurses might be available in some markets. For those markets without on-site reviewers, case management is provided via telephone. Check with the local market office to determine which facilities have on-site nurse reviewers. Disease management services also are available for a specific set of chronic conditions. Humana handles disease management services by phone.

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 coordinates discharge planning with the patient and/or patient’s representative and physician.

Q: Does Humana conduct concurrent review in all markets?

A: Yes, Humana conducts concurrent review in all network PFFS markets.

Q: What is the process for authorization or notification?

A: Inpatient admissions are not subject to prior authorization requirements for PFFS plans. Notifications of all inpatient admissions to a hospital or skilled nursing facility are requested (but not required) to maximize patient benefits, including disease and case management programs. Call **800-523-0023** for admission notification.

Q: Where can I find a list of services for which Humana requests prior notification?

A: The list can be found online at www.Humana.com/PAL.

Q: Does Humana’s MA Full Network PFFS plan 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 Medicare Advantage beneficiaries who are inpatients about their hospital discharge rights. The regulation requires that, upon admission, hospitals must provide and explain to all Medicare Advantage 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 the following:

- Right to benefits for inpatient and 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 no later 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 responsible for the inpatient care must concur with the discharge.

Q: Is there an on-site reviewer?

A: On-site nurses may be available in some markets. Certain cases are identified for case management on an outpatient basis through post-discharge calls to patients. Depending on their condition, certain patients are identified for further case management. Case management is handled by phone.

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.