Physician/Facility 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

Humana

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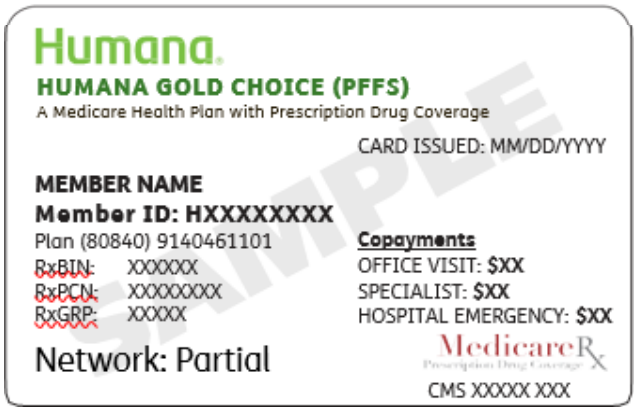
Humana PFFS member identification card information

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 non-contracted provider is governed by Humana's PFFS Terms and Conditions. To review 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 review the terms and conditions, 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 Humana.com/Provider (unsecure), and their contracts.

Q: How are non-contracted healthcare providers reimbursed?

A: Non-contracted healthcare providers are reimbursed according to Humana's PFFS Terms and Conditions.

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

A: Yes. NPIs, 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 PFFS plan and returns 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: If a patient disenrolls from Humana's MA PFFS 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 by visiting Humana.com/FindADoctor.

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

A: The payment dispute process is included in the 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 claims information online?

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

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, the provider 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, the provider can collect only the cost sharing that would apply for the service if the service were coverable. That is, the provider must not balance bill a patient with a MA Full Network PFFS or Partial Network PFFS plan for a non-covered 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 Inpatient Prospective Payment System (IPPS), 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 the Medicare Outpatient Prospective Payment System (OPPS), less certain components that Humana might not pay. In addition, Humana's MA Full network PFFS 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 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 MA organizations. Medicare pays these add-ons to providers directly through its CMS contractors (Medicare Administrative Contractor [MAC] for Parts A and B or 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 MA. 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 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 call 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: Are case management services available for Medicare Advantage network PFFS products?

A: Telephonic case management is available to MA 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 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 for Humana network PFFS plans are not subject to prior authorization requirements; however, notifications are requested for any admission to a hospital or skilled nursing facility. This notification helps the patient use case management and Humana disease management programs upon discharge.

Notifications may be initiated:

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

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

A: The list can be found online at 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 MA beneficiaries who are inpatients about their hospital discharge rights. The regulation requires that, upon admission, hospitals must 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 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: 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.