Humana

Grievances and Appeals/Inquiry Directory

Commercial – Federal No Surprises Act: QPA Disclosure/Payment Disputes

THIS IS NOT APPLICABLE FOR MEDICARE OR MEDICAID PLANS.

Commercial members are protected from balance billing when services are in scope for the No Surprises Act.

The No Surprises Act provides requirements regarding surprise medical billing for health plans, health insurers and providers, effective Jan. 1, 2022. The act also stipulates other consumer/patient protection and reporting requirements.

Services covered under the act:

- Out-of-network emergency services, including certain out-of-network post-stabilization services
- Nonemergency, ancillary services rendered by out-of-network providers at in-network facilities
- Nonemergency services (other than ancillary services) rendered by out-of-network providers at in-network facilities when the patient did not provide consent
- Out-of-network air ambulance services

Where the qualified payment amount (QPA) applies for purposes of the recognized amount, or in the case of air ambulance services for member cost share, QPA is reflected as the allowed amount and complies with the No Surprises Act.

Downcoded claims: To learn the amount that would have been the QPA if the service code or modifier had not been downcoded, call **800-448-6262**.

For claims subject to the No Surprises Act, you can initiate a 30-day open negotiation period if you disagree with the claim payment you received. You can do this via the MultiPlan Provider Portal at Provider.Multiplan.com, by calling the portal's customer service team at **888-593-7427** or by emailing MultiPlan at NSAService@multiplan.com. If a resolution is not reached through negotiation, either party can initiate the federal independent dispute resolution (IDR) process. Initiation must occur within 4 days of the end of the open negotiation period.

When initiating the IDR at www.cms.gov/nosurprises, use HumanaSurpriseBilling@Humana.com when completing the plan contact information to avoid delays.

Claim Payment Inquiries/Disputes

How to make a claim payment inquiry/dispute:

1. Humana's providers who have completed Availity Essentials™ registration can submit disputes using Availity Essentials.

    A. With this function, healthcare providers can:
        - Submit appeal and dispute requests for finalized Humana Medicare, Medicaid or commercial claims in a streamlined online process.
            – Claim details are automatically populated, making the submission process more efficient.
        - Upload supporting documentation for new and pending online requests.
        - Check the status of claim appeals, dispute requests submitted through Availity Essentials and review original submission details.
        - View high-level determinations for online requests that Humana has processed, along with the reason for the determination.

    B. For registration assistance or help with portal tools: Call Availity Client Services at 800-AVAILITY (282-4548), Monday – Friday, 8 a.m. – 8 p.m., Eastern time (excluding holidays).

2. Call Humana's provider call center at **800-448-6262**. Our representatives are trained to answer many of your claim questions and can initiate contact with other Humana departments when further review or research is needed.

    A. Note the reference number issued to you by the provider call center.

    B. If the call center representative is unable to adequately address your issue, you have the option to speak to a provider call center supervisor. Based on availability, you will be connected to a supervisor, or a supervisor will contact you within 48 hours of your request.

    C. In some situations, the call center representative will route your issue to an internal team at Humana. If this occurs, you will receive a letter or updated explanation of remittance (EOR) from the Humana department that completes the additional review/research. Most inquiries receive a response in 30 to 45 days. Please allow us time to properly research and resolve your inquiry before contacting us again.

3. Participating providers only: Once you have received our response to your initial inquiry, if you disagree with our determination and would like to dispute it, you can escalate your concern by sending a secure email to HumanaProviderServices@Humana.com. Please be sure to include:

    A. Reference number(s) associated with previous attempt(s) to resolve the inquiry (referenced in 2a above)

    B. The healthcare provider's name and Tax Identification Number

    C. The Humana member ID number and the member's relationship to the patient

    D. The date of service, claim number and name of the service providers

E. The charge amount, actual payment amount, expected payment amount and a description of the basis for the contestation

F. Contact information for our response

Please note: Standard email is not secure and may expose information to unauthorized parties. To access our secure portal, please visit Humana.com/Secure, then return documents to HumanaProviderServices@Humana.com.

4. Look for an "Acknowledgment of Submission" email with a tracking number within 5 business days of your submission. Please allow 30 to 45 days from the date of the acknowledgment notice for our response.

How to submit an appeal on Availity Essentials

1. Sign in to Availity Essentials (registration required).
2. If you don't have access to the Claim Status tool, contact your organization's Availity administrator.
3. Use the Claim Status tool to locate the claim you want to appeal or dispute, then select the Dispute Claim button on the claim details screen. This adds the claim to your Appeals worklist but does not submit it to Humana.
4. Submit the appeal or dispute to Humana immediately, or you can submit it later from your Appeals worklist.
5. To access your Appeals worklist at any time—either to complete a submission or to check the status of prior requests—from the Availity Essentials menu, go to Claims & Payments and select Appeals.

Medicare Advantage Grievances and Appeals

This information is for physicians and other healthcare providers who have provided care to Humana Medicare Advantage (MA) members. Participating providers do not have grievance and appeal rights on behalf of themselves, but they can appeal on behalf of their Humana-covered patients. Nonparticipating providers may appeal on behalf of themselves or on behalf of their Humana-covered patients.

If you believe the determination of a claim involving an MA plan is incorrect, you have the right to request an appeal as outlined above. The appeal will be reviewed by parties not involved in the initial claim or service denial to ensure unbiased review.

When submitting a grievance or an appeal, you can use the Humana Appeal, Complaint or Grievance Form designed for Humana members. (Please skip Section 4.) If you are a nonparticipating provider submitting an appeal about a claim on your own behalf, you also must submit a Waiver of Liability Statement. If you are a nonparticipating provider submitting an appeal on your patient's behalf, please also submit a completed Appointment of Authorized Representative Form. This will ensure we receive the information needed to process your request. **In addition, you have the option to submit a grievance and appeal through Availity Essentials using the steps here.**

Please submit your appeal request in writing within 65 calendar days from the date of the denial notice. This request should include:

- A copy of the original claim
- The remittance notification showing the denial
- Any clinical records and other documentation that support your argument for reimbursement

Nonparticipating providers appealing on their own behalf **must** provide a signed copy of the Waiver of Liability Statement to ensure Humana-covered patients will not be billed for any payment, regardless of the outcome of the appeal.

Once you have completed the request, please mail it to:

Humana
Grievance and Appeal Department
P.O. Box 14165
Lexington, KY 40512-4165

Forms

Waiver of Liability Statement
This form is required for nonparticipating providers requesting an appeal on their own behalf.

Appointment of Authorized Representative Form
Participating and nonparticipating providers should use this form when someone other than the member is appealing a claim and that person does not have an appointment of representation on file or another form of authorization, such as a power of attorney.

Appeal, Complaint or Grievance Form
This form can be used to submit an appeal, complaint or grievance.

How to submit an appeal on Availity Essentials

Medicaid, Dual Demonstration and Applicable Integrated Plans (AIP) Appeals

If you believe the determination of a claim is incorrect, please review your state laws and/or the applicable provider resources, linked below, for reconsideration rights. The reconsideration request will be reviewed by parties not involved in the initial determination.

To request a reconsideration, you need to submit your request in the applicable time frame specified under state law. This request should include:

- The remittance notification showing the denial
- Any clinical records and other documentation that support your case for reimbursement
- Any other documents as required by applicable state law or procedures

Reconsideration requests containing the documents listed above should be submitted online via Availity Essentials or mailed to the appropriate P.O. Box. For more information and mailing addresses, please see the following state-specific resources for Medicaid/dual plans:

Florida
Illinois
Indiana
Kentucky
Louisiana
Ohio
Oklahoma
South Carolina

Forms

Waiver of Liability Statement
This form is required for nonparticipating providers requesting an appeal on their own behalf.

Appointment of Authorized Representative Form
Participating and nonparticipating providers should use this form when someone other than the member is appealing a claim and that person does not have an appointment of representation on file or another form of authorization, such as a power of attorney.

Appeal, Complaint or Grievance Form
This form can be used to submit an appeal, complaint or grievance.

How to submit an appeal on Availity Essentials

Commercial Medical Claim Payment Reconsiderations and Appeals

This section contains information for Humana participating and nonparticipating physicians, hospitals and other healthcare providers about medical claim payment reconsiderations and member appeals.

Information for participating providers
Participating providers can find the reconsideration processes in the provider manuals for physicians, hospitals and healthcare providers at provider.humana.com/working-with-us/publications.

Reconsiderations and appeals for participating and nonparticipating providers
If you believe the determination of a claim is incorrect, you may file an appeal on behalf of the covered person with authorization from the covered person via mail or Availity Essentials. Some states may allow providers to file on their own behalf in certain circumstances. Please review the applicable state law for appeal rights.

The appeal will be reviewed by parties not involved in the initial determination. To request an appeal, submit your request in writing within the time limits set forth in the medical insurance policy if filing on behalf of the covered person. If filing on your own behalf, submit your written request within the time frame established by applicable state law. Please send the appeal to the following address:

Humana
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

In Puerto Rico, please use this address:

Humana
Unidad de Querellas y Apelaciones
P.O. Box 191920
San Juan, PR 00919-1920

Please include with your request:

- A copy of the original claim
- The explanation of remittance showing the denial
- Any clinical records and other documentation that support your case for reimbursement
- An Appointment of Authorized Representative Form or other legal documentation authorizing you to act on the covered person's behalf (if you are filing an appeal on behalf of a covered person)

Please note the commercial plan appeal process is the same for nonparticipating and participating providers.

How to submit an appeal on Availity Essentials

California DOI Contact Information – Request for Review

This information is for physicians and other healthcare providers who have rendered services to Humana-insured members in California.

If you are dissatisfied with the adjudication of a claim, you can request a review by the California Department of Insurance (DOI) at the following address:

State of California
Department of Insurance
Health Claims Bureau
300 S. Spring St.
Los Angeles, CA 90013

If you have questions, the department can be reached at **800-927-4357**, or you can consult the department's website at insurance.ca.gov.