Humana Dual Fully Integrated in Illinois
Provider Resource Guide

Welcome to Humana Dual Fully Integrated in Illinois, a program focused on helping people across the state achieve their best health. This provider resource guide includes tools and information to help network- and Illinois-designated providers—including long term services and supports (LTSS) providers—work with Humana. You can find updates to this provider resource guide on our Humana Dual Fully Integrated in Illinois provider website.

Online self-service

You can find a variety of provider materials and resources on our website, no registration required, including:

- Provider publications (e.g., provider manual, program updates)
- Preauthorization and notification list
- Prescription Drug Guide
- Compliance requirements
- Forms

Additional resources include:

- Availity Essentials™
- Medicare Part D redeterminations
- Illinois Department of Healthcare and Family Services (HFS), Illinois Medicaid Program Advanced Cloud Technology (IMPACT)
- Carelon Behavioral Health

Availity Essentials

Healthcare providers who want to work with Humana online can register for Availity Essentials at no cost. This multipayer portal allows providers to interact securely with Humana and other participating payers without learning to use multiple systems or remembering different user IDs and passwords for each payer. Many tools specific to Humana are accessible through Availity Essentials.

Humana®

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To learn more, call Availity Essentials at 800-282-4548, Monday – Friday, 7 a.m. – 7 p.m., Central time, or visit Availity Essentials. With Availity Essentials, you can:

- Check eligibility and benefits
- Submit referrals and authorizations for all services except LTSS
- Submit claims and check claim status
- View remittance advice
- View member benefit summaries
- Confirm/remedy overpayment
- Set up electronic funds transfer (EFT)
- Submit provider claim disputes
- Check provider claim dispute status

Humana LTSS home- and community-based services (HCBS)

Humana is here to support the patient's needs and daily living activities. A Humana care coordinator will manage these services, which include:

- Adaptive equipment rental and purchase
- Adult day service and transportation
- Agency and individual home health aide/certified nursing assistant (CNA)
- Automated medication dispenser
- Automated medication dispenser installation
- Day habilitation
- Home health intermittent nursing registered nurse (RN), licensed practical nurse (LPN) (agency provider)
- Home health intermittent nursing RN, LPN (individual provider)
- Home modification (environmental accessibility adaptations)
- Home-delivered meals
- Homemaker
- Nursing (multi-customer)
- Nursing facility
- Nursing/LPN (agency and individual)
- Nursing/RN (agency and individual)
- Occupational therapy
- Personal Emergency Response Services (PERS)/installation and monthly service
- Personal assistant
- Physical therapy
- Prevocational services

- Respite/adult day service
- Respite/adult day service transportation
- Respite/CAN for medically fragile/technology-dependent patients
- Respite/homemaker
- Respite/personal assistant
- Respite/RN and LPN
- Speech therapy (home and hospital)
- Supported employment
- Support-living facility

Humana will only cover those services deemed medically necessary. All LTSS services require an authorization. It is important that you email the LTSS authorization request to HUMLTSSTransitions@humana.com. Do not submit LTSS authorizations via Availity Essentials.

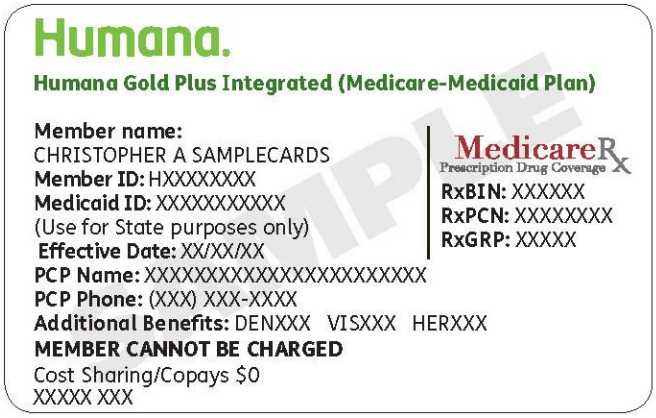
Each member is assigned a care coordinator who facilitates authorizations. Please submit PERS requests to care coordinators by emailing HUMLTSSTransitions@humana.com. If you would like additional information regarding care coordination services, please call Humana Dual Fully Integrated Customer Care at 800-787-3311 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m., Central time.

Member identification card

Please ask members to present their Humana identification card at the time of service.

Please note: These sample identification cards comply with state guidelines and can change without notice.

Frequently used contact information



Services	Phone number/email address	Hours of operation (all times Central)
Humana Dual Fully Integrated provider services	800-787-3311	Monday – Friday, 7 a.m. – 7 p.m.
Provider relations—Health plan support (e.g., copy of contract, fee schedule requests, credentialing status)	800-626-2741 ILProviderRelations@humana.com	Monday – Friday, 8 a.m. – 5 p.m.
Preauthorization assistance for medical procedures	800-523-0023	Monday – Friday, 7 a.m. – 7 p.m.
Preauthorization assistance for LTSS **Personal emergency response system**— Please note that requests for authorization for personal emergency response systems for LTSS members must be submitted to the member's care coordinator.	HumLTSStransitions@humana.com	N/A
Medication prior authorization—Step therapy, quantity limits and medication exceptions for medication supplied and billed through the pharmacy • Online submission is available at **CoverMyMeds**. • Forms also are available on the **prior authorization for pharmacy drugs webpage**.	800-555-2546 Fax: 877-486-2621	Monday – Friday, 7 a.m. – 10 p.m.
Medication intake team—Prior authorization for medication administered in a medical office. • Forms are available on the **prior authorization for professionally administered drugs webpage**.	866-461-7273 Fax: 888-447-3430	Monday – Friday, 7 a.m. – 5 p.m.
Medication Therapy Management program	833-349-4114 (TTY: 711)	Monday – Friday, 8 a.m. – 4:30 p.m.
CenterWell Pharmacy®—Mail order for maintenance medications	800-379-0092 (TTY: 711) Fax: 800-379-7617	Monday – Friday, 7 a.m. – 10 p.m., and Saturday, 7 a.m. – 5:30 p.m.
CenterWell Specialty Pharmacy®	800-486-2668 (TTY: 711) Fax: 877-405-7940	Monday – Friday, 7 a.m. – 10 p.m. Saturday, 7 a.m. – 5 p.m.
Pharmacy appeals	Fax: 877-556-7005	N/A

Services	Phone number/email address	Hours of operation (all times Central)
Claim payment inquiries	800-787-3311 or Availity Essentials	Monday – Friday, 7 a.m. – 7 p.m.
A**vaility Essentials**	800-AVAILITY (282-4548)	Monday – Friday, 7 a.m. – 7 p.m.; press **0** for live assistance
Provider payment integrity customer service—Confirm/remedy overpayment as well as inquire about/review issues related to financial recoveries	800-438-7885	Monday – Friday, 7 a.m. – 7 p.m.

Important addresses

Contact name	Address
Provider Correspondence and Disputes	**Humana Provider Correspondence** P.O. Box 14359 Lexington, KY 40512-4359 or **Availity Essentials**
Member Grievances and Appeals	**Humana Health Plans** P.O. Box 14546 Lexington, KY 40512-4546
Humana Claims Office	**Humana Claims Office** P.O. Box 14359 Lexington, KY 40512-4359 or **Availity Essentials**
Carelon Behavioral Health Claims Department	**Paper Claims Carelon Health Options** Attn: Claims Department P.O. Box 1866 Hicksville, NY 11802-1866
Quality Investigations	**Quality Investigations** 3401 SW 160th Ave., Bldg. A, 1st Floor Miramar, FL 33027-6305
Pharmacy Appeals	**Humana** Grievances and Appeals P.O. Box 14163 Lexington, KY 40512-4163

Other network information

Required networks/vendor name	Phone number	Hours of operation (all times Central)
Carelon Behavioral Health	800-397-1630	Monday – Friday, 7 a.m. – 7 p.m.
MTM, Inc.—nonemergency transportation vendor	855-253-6867	Monday – Friday, 8 a.m. – 8 p.m.

National Provider Identifier

Unless you are an atypical provider, you must have a National Provider Identifier (NPI) in accordance with Section 1173(b) of the Social Security Act, as enacted by Section 4707(a) of the Balanced Budget Act of 1997. Atypical providers (e.g., waiver services provider) should submit claims using their Tax Identification Number (TIN) and their Healthcare and Family Services (HFS) Medicaid number.

If you submit a claim without including a valid NPI and you are not an atypical provider, you will need to submit a corrected claim that includes your NPI and matches the taxonomy code to receive reimbursement. All NPIs and IMPACT Medicaid IDs must match on the claim. Humana does not pay claims in which the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered categories of service.

Illinois Medicaid provider number

All providers must have a unique state Medicaid provider number that is obtained as part of enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) program in accordance with Illinois Department of HFS guidelines. An entity that bills Humana for Medicaid-reimbursable services provided to Medicaid recipients in Illinois, or that provides billing services for all Medicaid provider types, must be active and enrolled as a Medicaid provider or have "limited enrollment status" in the HFS IMPACT provider enrollment system to receive reimbursement. To verify enrollment, you can sign into the HFS IMPACT provider enrollment system. Find out more at the IMPACT site.

Dual Medicare-Medicaid plan preauthorization list

Humana requires preauthorization for certain services to facilitate care coordination and confirm the services are provided according to Centers for Medicare & Medicaid Services (CMS) and HFS coverage policies. Prior to providing a service to a patient with Humana Dual Fully Integrated coverage, you should determine whether preauthorization is required by reviewing the Medicare and dual Medicare-Medicaid plan preauthorization and notification list on our prior authorization and notification lists or by calling Humana Provider Services at 800-787-3311 (TTY: 711), Monday – Friday, 7 a.m. – 7 p.m., Central time. Please note that the preauthorization list is subject to change.

Some specialists do not require a referral from a primary care provider, such as women's healthcare providers. The requirement and/or status of a referral can be verified by accessing Availity Essentials or by calling Humana's Clinical Intake team at 800-523-0023, Monday – Friday, 7 a.m. – 7 p.m., Central time.

Nonbehavioral health claim submission

For nonbehavioral health claims, Humana accepts electronic and paper claim submissions. For questions on how to enroll in electronic claim submissions, please call 800-282-4548, Monday – Friday, 7 a.m. – 7 p.m., Central time, or go to Availity Essentials. Paper claims should be submitted to the address listed on the back of the member's Humana ID card.

Initial claims must be submitted within 180 days of the date of service or discharge. Providers have 365 days from the date of remittance to resubmit a claim or the original payment is considered full and final for the related claims. If a member has other insurance coverage and Humana is secondary, providers must submit the claim for secondary payment within 90 calendar days after the final determination of the primary payer and in accordance with the Medicaid Provider General Handbook.

Humana can only process clean claim submissions; unclean claims are not processed and are returned to the provider for correction. A clean claim is a submission that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party.

Behavioral health claim submission

For behavioral health claims, Carelon must receive claims for covered services within 180 days of the dates of service on outpatient claims and within 180 days of the date of discharge on inpatient claims. Electronic claims may be submitted directly to Carelon via an 837 file or the provider website (registration required) with the Carelon payer ID BHOVO. Mail paper claims to:

Carelon Health Options
Attention: Claims Department
P.O. Box 1866
Hicksville, NY 11802-1866

Common claim submission errors and how to avoid them

Humana may reject claims because of missing or incomplete information. Common rejection or denial reasons include:

- Patient not found
- Subscriber not found
- Patient date of birth on claim not matching that found in the database
- Missing or incorrect information
  - Incorrect NPI/ZIP code/taxonomy
  - Missing NPI/ZIP code/taxonomy
  - Encounters with $0 value
- Invalid Healthcare Common Procedure Coding System (HCPCS) code
- No authorization found

Ways to avoid these errors include:

- Confirming received and submitted patient information is complete and accurate
- Ensuring all required claim form fields are complete and accurate

- Ensuring billed amounts have a dollar value
- Obtaining proper authorization for rendered services

Humana's clearinghouse information—electronic data interchange

Availity Essentials is Humana's preferred claims clearinghouse, but you can use other clearinghouses as well. The following list contains some of the frequently used clearinghouses.

Clearinghouse
Availity Essentials
Change Healthcare®
TriZetto®
SSI Group

Humana payer ID	
Fee-for-service claims (noncapitated)	**61101**
Encounters (capitated)	**61102**

Note: Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

Claim payments

Get paid faster and have your Humana claim payments deposited automatically with EFT and electronic remittance advice (ERA). Visit our coverage and claims webpage or call Humana Provider Services at 800-787-3311 (TTY: 711), Monday – Friday, 7 a.m. – 7 p.m., Central time, for more information on EFT and ERA.

Contractual and demographic changes

Humana requires contracted providers to send notification of legal and demographic changes. This ensures provider directory and claim processing accuracy. Examples of changes that require notification include updates to:

- Provider TIN
- Providers added to or leaving the group
- Service address (e.g., new location, phone, fax)
- Access to public transportation
- Standard hours of operation or after-hours availability
- Billing address
- Credentialing status
- Panel status
- Languages spoken in the office

Annual compliance training

Humana supports healthcare providers in their efforts to provide care to patients with Medicare-Medicaid coverage by offering training materials to help them meet state and federal compliance requirements:

- Humana Illinois Medicare-Medicaid Provider Orientation
- Humana Illinois Medicare-Medicaid Provider Training
- Health, Safety and Welfare Training
- Cultural Competency Training
- General Compliance and Fraud, Waste and Abuse Training

Provider compliance training is available on Availity Essentials. Select Payer Spaces > Humana > Humana Learning Center to locate Humana's training materials. More information is available on our provider compliance training materials webpage.

Member eligibility

Individuals must be eligible for both Medicaid and Medicare and be at least 21 years old to be eligible for enrollment in the Humana Dual Fully Integrated plan. The Medicaid-eligible disabled adult designation also includes certain home- and community-based waiver members. Since member eligibility changes frequently, providers are advised to verify a member's eligibility on admission to or initiation of treatment and on each subsequent day or date of service to facilitate reimbursement for services. To verify eligibility for a member receiving behavioral health services, providers can check Carelon's e-services or call Carelon Provider Services at 855-481-7044, Monday – Friday, 7 a.m. – 5 p.m., Central time. Eligibility for all other services can be verified by going to Availity **Essentials**, navigating to Patient Registration, then selecting Eligibility and Benefits Inquiry.

Covered benefits

Humana provides the same covered benefits that members would receive if they were dually enrolled in original Medicare and state Medicaid programs. Humana also offers value-added benefits, which are benefits offered by Humana that are above and beyond what HFS requires Humana to cover.

Humana's value-added benefits include the following:

- Up to $65 per quarter for certain over-the-counter items not covered by Medicaid
- Unlimited rides to and from medically necessary appointments and to the pharmacy right after a provider visit
- 14 refrigerated home-delivered meals after an overnight stay in a hospital or nursing home
- Additional dental care benefits
- $0 copay for other covered healthcare services
- 30- or 90-day prescriptions mailed to the member's home from in-network, mail-order pharmacies

Medical copayments

You may not charge members copays for medically covered services, including:

- Provider visits
- Hospital stays
- Emergency room (ER) visits
- Prescri ptions

Member balance billing

Providers cannot balance bill, charge, seek payment or have any recourse against Humana or members for any amounts related to the provision of healthcare services for which privileges have not been granted to providers by Humana.

Cost sharing

The state is required by law to pay Medicare cost-sharing expenses for Qualified Medicare Beneficiaries (QMBs) whose income and resources are at or below the QMB income and resource standards. For QMBs who meet these requirements, the state pays Medicare cost-sharing expenses. The cost share is paid by Humana. Humana covers both Medicare- and Medicaid-covered copayments and/or cost shares.

Continuity of care

Humana offers an initial 90-day transition period for new demonstration members to maintain a current course of treatment with an out-of-network provider. Humana also offers a 90-day transition period for members transitioning to Humana from another demonstration plan. The 90-day transition periods are applicable to all providers, including behavioral health providers and

LTSS providers. Nonparticipating primary care providers and specialists providing an ongoing course of treatment will be offered single-case agreements to continue member care beyond the transition period if they remain outside the network or until a qualified, affiliated provider is available.

Care management

Humana Dual Fully Integrated members are assigned to a care coordinator on enrollment. The care coordinator conducts regular assessments, develops a comprehensive care plan and assists members with access to needed services. As part of the care plan development process, care coordinators request input from providers through an interdisciplinary care team meeting. If you would like additional information regarding care coordination services, please call Humana Provider Services at 800-787-3311 (TTY: 711), Monday – Friday, 7 a.m. – 7 p.m., Central time.