Humana Gold Plus Integrated Medicare-Medicaid Alignment Initiative in Illinois

Provider Resource Guide

Welcome to the Humana Gold Plus® Integrated Medicare-Medicaid Alignment Initiative (MMAI) in Illinois, an MMAI program focused on helping members achieve their best health. This provider resource guide includes tools and information to assist network- and Illinois-designated providers in working with Humana. You can find updates to this provider resource guide on our **Humana Gold Plus Integrated MMAI in Illinois provider website**.

Online self-service

Various provider materials and resources are available on our **website**, no registration required. MMAI-specific **provider documents, training materials** and communications also are available on this website, including:

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

Additional resources include:

- **Availity Essentials**
- **Long-term Service and Support (LTSS) Resource Guide**
- **Medicare Part D redeterminations**
- **Illinois Department of Healthcare and Family Services (HFS), Illinois Medicaid Program Advanced Cloud Technology (IMPACT)**
- **Carelon Behavioral Health**

Humana®

Humana Gold Plus Integrated (Medicare-Medicaid plan) is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to members.

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Frequently used contact information

Services	Phone number/ email address	Hours of operation (all hours of operation in Central time)
Humana MMAI provider services	**800-787-3311**	Monday through Friday, 7 a.m. to 7 p.m.
Provider relations—Health plan support (e.g., copy of contract, fee schedule requests, credentialing status, etc.)	**800-626-2741**	Monday through Friday, 8 a.m. to 5 p.m.
Preauthorization assistance for medical procedures	**800-523-0023**	Monday through Friday, 7 a.m. to 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**	
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 through Friday, 7 a.m. to 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 through Friday, 7 a.m. to 5 p.m.
Medication Therapy Management program	**888-210-8622 (TTY: 711)**	Monday through Friday, 8 a.m. to 4:30 p.m.
CenterWell Pharmacy®—Mail order for maintenance medications	**800-379-0092 (TTY: 711)** Fax: **800-379-7617**	Monday through Friday, 7 a.m. to 10 p.m., and Saturday, 7 a.m. to 5:30 p.m.
CenterWell Specialty Pharmacy®	**800-486-2668 (TTY: 711)** Fax: **877-405-7940**	Monday through Friday, 7 a.m. to 10 p.m. Saturday, 7 a.m. to 5 p.m.
Pharmacy appeals	Fax: **877-556-7005**	
Claim payment inquiries	**800-787-3311** or Availity Essentials	Monday through Friday, 7 a.m. to 7 p.m.

Services	Phone number/ email address	Hours of operation (all hours of operation in Central time)
Availity Essentials™	**800-AVAILITY (282-4548)**	Monday through Friday, 7 a.m. to 7 p.m.; press 0 for live assistance
Provider payment integrity customer service—Confirm/remedy overpayment as well as inquire/review issues related to financial recoveries	**800-438-7885**	Monday through Friday, 7 a.m. to 7 p.m.
Fraud, waste and abuse reporting		
Humana Special Investigations Unit (SIU) Hotline	**800-614-4126**	
Humana Ethics Help Line	**877-5-THE-KEY (584-3539)**	
Illinois Department of HFS Medicaid/Welfare Fraud Hotline	**844-ILFRAUD (453-7283)**	

Important addresses

Contact name	Address
Provider Correspondence and Disputes	Humana Provider Correspondence P.O. Box 14601 Lexington, KY 40512-4601 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 14601 Lexington, KY 40512-4601 or **Availity Essentials**
Carelon Behavioral Health Claims Department	Paper ClaimsCarelon Health Options Attention: Claims Department P.O. Box 1866 Hicksville, NY 11802-1870
Quality Investigations	Quality Investigations 3401 SW 160th Ave., Bldg. A, 1st Floor Miramar, FL 33027-6305
Pharmacy Appeals	Humana Inc. Grievance and Appeal P.O. Box 14546 Lexington, KY 40512-4546

Other network information

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

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.

To learn more, call **Availity Essentials** at **800-282-4548**, Monday through Friday, 7 a.m. to 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

National Provider Identifier

Unless you are an atypical provider, you are required to 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 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 in order 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 state's IMPACT program in accordance with Illinois Department of HFS guidelines. An entity that bills Humana for Medicaid-reimbursable services provided to Illinois Medicaid recipients, 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 in order to receive reimbursement. To verify enrollment, you can sign into the HFS IMPACT provider enrollment system. You can 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 MMAI 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** webpage or by calling Humana Provider Services at **800-787-3311**, Monday through Friday, 7 a.m. to 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 through Friday, 7 a.m. to 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 through Friday, 7 a.m. to 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. Paper claims should be mailed to the following mailing address:

Paper Claims
Carelon Health Options Attention: Claims Department
P.O. Box 1866
Hicksville, NY, 11802-1870

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 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
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**, Monday through Friday, 7 a.m. to 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

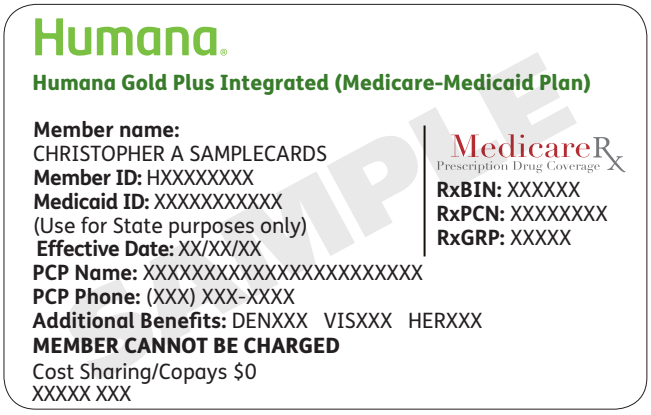
Humana supports healthcare providers in their efforts to provide care to patients with Medicare-Medicaid coverage by offering training materials to help them meet state and federal compliance requirements. Humana has a variety of materials available on our **website**, including:

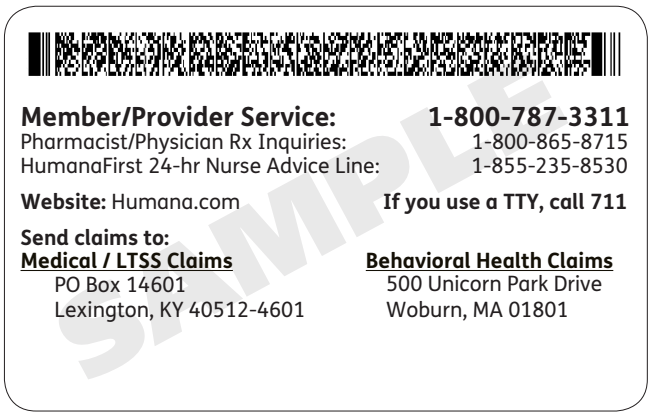
- Humana Illinois Medicare-Medicaid Provider Orientation
- Humana Illinois Medicare-Medicaid Provider Training
- Health, Safety and Welfare Training
- Cultural Competency Training
- General Compliance and Fraud, Waste and Abuse Training

Provider compliance training also is available at **Availity Essentials** in the Humana Payer Spaces Resource tab. More information is available on our **provider compliance training materials** webpage.

Member ID card samples

Please ask members to present their ID card at the time of service. Photos of sample member ID cards are included below.





Please note: These sample IDs comply with state guidelines. They are subject to change without notice.

Member eligibility

Individuals must be eligible for both Medicaid and Medicare and be at least 21 years of age to be eligible for enrollment in the Humana Gold Plus Integrated MMAI 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 through Friday, 7 a.m. to 5 p.m., Central time. Eligibility for all other services can be verified by going to **Availity Essentials** and navigating to Patient Registration and then selecting Eligibility and Benefits Inquiry.

Continuity of care

Humana offers an initial 180-day transition period for new demonstration members to maintain a current course of treatment with an out-of-network provider. Humana offers a 90-day transition period for members transitioning to Humana from another demonstration plan. The 180-day and 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.

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-day 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

•Prescriptions

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-covered and Medicaid-covered copayments and/or cost shares.

Care management

Humana Gold Plus Integrated MMAI 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**, Monday through Friday, 7 a.m. to 7 p.m., Central time.