Humana Dual Integrated (HMO D-SNP) in Michigan
Provider Resource Guide

Welcome to Humana Dual Integrated (HMO D-SNP) in Michigan, a Medicaid and Medicare managed care program focused on helping enrollees achieve their best health. This provider resource guide includes tools and information to assist network and Michigan-designated providers in working with Humana. You can find updates to this provider resource guide at Humana.com/HealthyMI.

This provider resource guide applies only to providers in Humana's Medicare HMO network or Humana's Medicaid network who serve enrollees in the Humana Dual Integrated (HMO D-SNP) in Michigan program. All other Special Needs Plan products are out of scope for this resource guide. If you are serving an enrollee in another plan, and need more information, please refer to Humana's Medicare manual on our website at Humana.com/Publications.

About the Humana Dual Integrated (HMO D-SNP) in Michigan

Effective Jan. 1, 2026, the Michigan Department of Health and Human Services (MDHHS) transitioned from the Michigan Health Link program to Michigan Coordinated Health. Humana is honored to participate in this program, where we offer a Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP). A HIDE-SNP is a type of Medicare Advantage (MA) plan designed for individuals who are eligible for Medicare and Medicaid benefits.

Humana offers 1 HIDE-SNP in Michigan: Humana Dual Integrated H0963-001-000 (HMO D-SNP) which serves enrollees in Macomb (Region 10) and Wayne (Region 12) counties for Plan Year 2026. Beginning Jan. 1, 2028, the plan also will be available in Regions 2–7, 9 and 11. This plan is referred to as HIDE-SNP throughout the rest of this resource guide.

The HIDE-SNP provides comprehensive coverage, including Medicare, most Medicaid benefits, long-term services and supports, and Medicaid behavioral health services not covered by regional pre-paid inpatient health plans (PIHPs).

Behavioral health services overview in Humana's HIDE-SNP in Michigan

Humana manages behavioral health (BH) and substance use disorder (SUD) services through its provider network and coordination with Community Mental Health Service Programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs). Humana is the responsible payor for all enrollees' Medicare coverage of behavioral health benefits. An enrollee's Medicare coverage is primary to the Medicaid coverage and must be considered first before applicable Medicaid coverage on the plan is considered.

Basic behavioral health services can be provided through primary care, including mental health and substance use screenings, prevention services, early intervention services, medication management, treatment services and referral to specialty services.

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Humana Dual Integrated (D-SNP) is a Dual Eligible Special Needs Plan (D-SNP) with a Medicare contract and a Medicaid contract with the Michigan Department of Health & Human Services (Medicaid)
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Humana coordinates a comprehensive range of basic and specialized BH services, including mild to moderate BH/SUD needs, through Humana's contracted provider network and/or coordination with local CMHSPs and PIHPs, such as Detroit Wayne Integrated Health Network (DWIHN) and Macomb County Community Mental Health Services (MCCMHS).

Enrollees with more severe or complex behavioral health/SUD conditions, such as serious mental illness, serious emotional disturbance or intellectual disabilities, are managed through local PIHPs. PIHPs and providers can refer enrollees to appropriate behavioral health/SUD services by contacting the local PIHP.

For Medicaid coverage under the Michigan HIDE-SNP program, PIHPs manage Medicaid specialty services consistent with Michigan's 1115 Behavioral Health Waiver, which includes mental health and substance use services for Medicaid-eligible individuals who have a need for behavioral health, intellectual/developmental disability services, supports and substance use services. Humana is responsible for covering all Medicaid covered behavioral health services not provided by PIHPs.

Primary care providers (PCPs) are required to:

- Provide basic behavioral health services to enrollees, including:
  - Screening for mental health and SUD issues during routine and emergency visits
  - Prevention and early intervention
  - Medication management
  - Treatment for mild to moderate behavioral health conditions
- Refer or assist enrollees finding a specialized behavioral health provider for severe or chronic behavioral health SUD conditions.
- Follow up with behavioral health providers to coordinate integrated and unduplicated care to the enrollee.
- Obtain a necessary signed release of information for the sharing of PHI, including compliance with 42 C.F.R. Part 2 requirements around behavioral health and SUD.

Humana assists with referrals, scheduling appointments and coordinating an integrated approach to the enrollee's health and well-being by coordinating care between behavioral health providers, PCPs and specialists.

For more information about behavioral health processes, please refer to the behavioral health section of the Humana HIDE D-SNP Michigan Provider manual, found online at Provider.Humana.com/medicaid/michigandsnp/training.

Long-term services and supports overview in Humana's HIDE-SNP in Michigan

Humana entered into a relationship with the Detroit Area Agency on Aging (DAAA), a nonprofit organization that serves older adults, adults with disabilities, and caregivers, to provide network management services and service coordination for all home- and community-based (HCBS) waiver services and state plan personal care services as part of this program. Providers will need to contract with the DAAA to provide services to Humana enrollees who are enrolled in the program. The DAAA will be required to adhere to the contractual requirements outlined by the state. Specific information, such as requesting prior authorization, submitting claims contracting are managed directly by the DAAA.

As an LTSS professional, you play an important role in the delivery of healthcare services to Humana enrollees. Services are to be provided in accordance with an individualized care plan developed by Humana in consultation with the enrollee, and includes services determined through an assessment by Humana (either directly or through a subcontractor/DAAA) to be necessary to address the health and service needs of the enrollee.

Through its contracted providers, Humana is required to arrange medically necessary services for each enrollee. When providing covered services to plan enrollee, you must adhere to applicable plan coverage provisions and all applicable state and federal laws. For a complete list of long term services and supports (LTSS)-covered services, please refer to the LTSS Covered Services benefit grid section within the Humana HIDE-SNP in Michigan Provider Manual, found online at Provider.Humana.com/medicaid/michigandsnp/training.

For more information on DAAA, please refer to the DAAA provider manual. Providers can email Humana LTSS care coordinators at HumLTSStransitions@humana.com to request LTSS services on behalf of a Humana-covered enrollee.

Online self-service

A variety of healthcare provider resources are available on the public website at Humana.com/HealthyMI, no registration required. This website also includes other information related to:

- Claim resources
- Network notices
- Pharmacy resources
- Health and wellness programs
- Clinical practice guidelines
- Provider training materials
- Provider publications, including the provider manual, newsletters and program updates

Frequently used contact information

Contact description	Contact information	Hours of operation
Care coordination	Phone: 877-264-2547 (TTY: 711) Fax: 844-252-1705	Monday – Friday, 9 a.m. – 6 p.m., Eastern time
Claim payment inquiries	855-281-6070	Monday – Friday, 7 a.m. – 8 p.m., Eastern time
Detroit Area Agency on Aging	Phone: 313-446-4444 Email: contractmgt@daaa1a.org	Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time
Enrollee eligibility	Online at Availity Essentials™ Patient registration, eligibility and benefits inquiry Phone: 800-282-4548	Monday – Friday, 8 a.m. – 8 p.m., Eastern time

Contact description	Contact information	Hours of operation
Member customer service	855-281-6070	Available 7 days a week, Oct. 1st to March 31st Monday – Friday, April 1st – September 30th, 8 a.m. – 8 p.m., Eastern time
Prior authorization requests for behavioral health: Clinical Intake Team (CIT)	Sign in to Availity Essentials at Availity.com (registration required) Phone: 855-281-6070 Fax: 502-322-8577	Monday – Friday, 7 a.m. – 8 p.m., Eastern time
Prior authorization for pharmacy/Humana clinical pharmacy review (HCPR)	Phone: 800-555-CLIN (800-555-2546) (TTY:711) Fax: 877-486-2621	Monday – Friday, 8 a.m. – 11 p.m., Eastern time
Prior authorization requests for physical health: Clinical Intake Team (CIT)	Sign in to Availity Essentials at Availity.com (registration required) Phone: 855-281-6070 Fax: 502-318-3351	Monday – Friday, 7 a.m. – 8 p.m., Eastern time
Provider Relations inquiries	MIProviderrelations@humana.com Link to territory map	We make every attempt to respond to emails within 48 hours.
Provider Services	855-281-6070	Monday – Friday, 8 a.m. – 8 p.m., Eastern time
TTY	711	Monday – Friday, 8 a.m. – 8 p.m., Eastern time

Fraud, waste and abuse reporting		
Special Investigations Unit (SIU)	Direct line: 800-558-4444, ext. 1500724 Hotline: 800-614-4126 Email: SIUReferrals@humana.com or ethics@humana.com	Direct line: Monday – Friday, 10 a.m. – 6 p.m., and 8 a.m. – 5:30 p.m., Eastern time Hotline: 24 hours a day, 7 days a week
Ethics helpline	877-5-THE-KEY (877-584-3539)	24/7 access

Important addresses

Humana department	Address
Claims submissions	Humana medical claims | submit via mail to: **Humana Claims** P.O. Box 14359 Lexington, KY 40512-4359
Encounter submissions	Humana encounters | submit via mail to: **Humana Encounters** P.O. Box 14055 Lexington, KY 40512-4055
Enrollee grievances and appeals	**Humana Health Plans** P.O. Box 14163 Lexington, KY 40512-4163
Special Investigations Unit (SIU)	Mail: **Humana** Special Investigations Unit 1100 Employers Blvd. Green Bay, WI 54344
Provider correspondence	**Humana** Attn: Provider Correspondence P.O. Box 14359 Lexington, KY 40512-4359

Availity Essentials

Healthcare providers who want to work with Humana online can register for Availity Essentials at no cost. Availity Essentials is a secure multi-payer portal that lets you interact with Humana and other participating payers without using multiple systems or remembering separate user IDs and passwords. In the Availity Essentials portal, we provide many Humana-specific tools for our network of participating providers.

Learn how to register for Availity Essentials by visiting Availity Essentials' Getting Started online resource at www.availity.com/documents/learning/LP_AP_GetStarted/index.html#/.

To find out more, call Availity Essentials at 800-282-4548, Monday – Friday, 8 a.m. – 8 a.m., Eastern time, or visit Availity Essentials. Availity Essentials provides access to the following:

- Certificates of coverage
- Claim submission and status
- Appeals
- Eligibility and benefits
- Electronic remittance advice (ERA)/electronic funds transfer (EFT) enrollment
- Humana-specific applications, resources and news
- Medical record requests

- Enrollee summary
- Overpayment management
- Plan of care
- Provider directory
- Referrals and authorizations
- Remittance advice
- Status of prior authorization and referral requests

Get paid faster and have your Humana claim payments deposited automatically with electronic funds transfer (EFT) and electronic remittance advice (ERA). Visit Provider.Humana.com/coverage-claims/electronic-payment-options for more information on EFT and ERA.

To access Availity Essentials training content, please:

1. Sign in to your Availity Essentials account.
2. Select Help & Training.
3. Select Get Trained to launch the Availity Learning Center.

To access Humana-specific training content, please:

1. Log in to your Availity Essentials account
2. Click on Payer Spaces > Humana > Humana Learning Center
3. Select the category "Compliance training"
4. Search for the current year training for Michigan (or any state(s) in which you are contracted)

Referrals

If an enrollee requires specialized treatment beyond the scope of a PCP, the enrollee may see an in-network specialist for consultation and/or treatment without a referral from their PCP. For enrollees with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, Humana allows enrollees to directly access a specialist without a referral as well.

After the patient is treated, the specialist's findings, diagnosis and recommendations for treatment should be sent to the patient's PCP. The specialist also must submit claim/encounter data to Humana.

Humana provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

Original Medicare does not cover some services or supplies when they are ordered/referred unless certain requirements (e.g., qualifications of the ordering/referring provider, billing requirements) are satisfied. For HIDE-SNP enrollees, Humana follows original Medicare billing and enrollment requirements for services and supplies covered under original Medicare.

Behavioral health referral procedures

Under Michigan's HIDE-SNP program, behavioral health and SUD services are managed through a combination of PIHPs and Humana.

Humana and the PIHPs agreed to process behavioral health referrals. These include:

- PIHPs make reasonable efforts to assist mutually served enrollees in understanding Humana's role and how to contact Humana.
- Humana makes reasonable efforts to assist mutually served enrollees in the PIHP's role and how to contact the PIHP.
- PIHPs and Humana encourage and maintain plan-to-plan and plan-to-PCP communications and collaborations.
- Humana and PIHPs make reasonable efforts to rapidly determine and provide the appropriate type, amount, scope and duration of medically necessary services.
- Humana makes a referral to the PIHP for an assessment for SUD, behavioral health needs or I/DD needs, as quickly as the mutually served enrollee's needs require, and no longer than within 5 calendar days from the date the need for an assessment was identified and in accordance with the requirements of Humana's contract with MDHHS.
- The PIHP must make best efforts to conduct necessary behavioral health assessments, as quickly as the mutually served enrollees needs require, in accordance with the requirements of the PIHP's contract with MDHHS, and no longer than within 15 calendar days of receiving a referral from the HIDE-SNP.
- When making a referral to a PIHP or its subcontractor(s), Humana communicates with the PIHP receiving the referral to inform them of a referral for the mutually served enrollee. The PIHP team should receive relevant background information, including social determinants of health (SDOH) screenings, and should have the necessary expertise to assist the mutually served enrollee.
- Humana and PIHPs agree to track referrals and conduct further outreach to mutually served enrollees, and/or Humana and the PIHP, or their contracted behavioral health providers, if necessary.
- Humana and the PIHP develop, provide, and update specific written behavioral health referral processes and contacts. Humana and PIHPs develop and maintain processes for multi-lateral referral tracking and service access metrics.

If you have questions regarding these processes or wish to verify available behavioral health and SUD benefits, please contact Provider Services at 855-281-6070, Monday – Friday, 8 a.m. – 8 p.m., Eastern time. For more information on behavioral health claims and the PIHPs, please refer to the Humana Behavioral Health Claims Provider Resource Guide.

Prior authorization submission

All services that require prior authorization from Humana should be authorized before the service is delivered. Humana is not able to pay claims for services in which prior authorization is required but not obtained. If prior authorization is required but not obtained, the discrepancy may result in a reduction or denial of payment. To determine which services require prior authorization, please access our Prior Authorization and Notification List at Humana.com/PAL under the Medicare tab, or call Provider Services at 855-281-6070, Monday – Friday, 8 a.m. – 8 p.m., Eastern time. It is important to request prior authorization as soon as you know that a Humana-covered patient requires a service on the Prior Authorization Notification List. The enrollee, their PCP or their treating provider is responsible for initiating a request for services. Online requests are encouraged through Availity Essentials, our secure, payer-agnostic provider portal, but prior authorizations can be requested through any of the following methods:

- Sign in to Availity Essentials at www.availity.com (registration required). For select services, you

can answer a series of questions when requesting the preauthorization. If approved, you receive notification immediately. If the prior authorization request is pended for further review, you can attach relevant clinical information to the request to expedite the process.

- Submit a business to business or batch Health Care Services Review and Response transaction (278) via EDI.
- Use our interactive voice response system (IVR) by calling 800-523-0023.
- Call the number for preauthorization on the back of the patient's Humana ID card.
- Call 800-523-0023 if a request needs to be expedited due the seriousness of a patient's condition.

If an enrollee requires medically necessary services from a nonparticipating provider, please call the Humana Clinical Intake Team at 855-281-6070, Monday – Friday, 7 a.m. – 8 p.m., Eastern time to obtain prior authorization. You can view the status of your prior authorization requests by visiting Availity Essentials.

Long-term care coordination and service authorization

LTSS service authorizations for home- and community-based waiver services and state plan personal care services are created by the HCBS care coordinator employed by the DAAA.

The care coordinator completes a comprehensive assessment and works with the enrollee to identify care needs and identify resources to meet those needs. The care coordinator creates the LTSS service plan during the visit. If care needs exceed the state-provided service cost maximums, then the service authorization request is sent to the LTSS management team for further evaluation and review for medical necessity based on enrollee care needs. Service denials or reductions are issued from the medical director. Providers can request LTSS services, but all service authorization additions or changes must go through the care coordinator and be based on enrollee assessment of needs. Providers can email Humana LTSS care coordinators at HumLTSStransitions@Humana.com to request LTSS services on behalf of a Humana-covered enrollee.

For home and community-based waiver services and state plan personal care services, Humana contracts with the Detroit Area Agency on Aging for claims management, adjudication, and payment. Providers of these services must submit claims through the process identified by the Detroit Area Agency on Aging.

Claim processing

Claims must be submitted within 1 year from the date of service or discharge. We do not pay claims with incomplete, incorrect or unclear information.

If you do not agree with the decision on a processed claim, you have 60 days from receipt of notification that payment for a submitted claim was reduced or denied to submit an appeal.

If you indicate that a claim was not paid at your contracted rate, you may submit a dispute which must be received by Humana within 60 days of the original claim adjudication date.

If the claim appeal is not submitted in the required time frame, the claim is not considered and the appeal is denied.

Submitting an electronic claim

Healthcare providers can use Availity Essentials and EDI services as no-cost solutions for submitting claims electronically. To register for Availity Essentials or to learn more about Availity Essentials claims solutions, visit Availity Essentials at www.availity.com.

Healthcare providers also can file a claim by EDI through the clearinghouse of their choice. Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for information.

If submitting a claim to a clearinghouse, use the following payer IDs for Humana:

- Claims: 61101 (for fee-for-service claims/non-capitated)
- Encounters: 61102 (capitated)

Paper claims should be submitted to the address listed on the back of the enrollee's ID card or to the appropriate address listed below:

Claims	Encounters
Humana Claims Office	**Humana Claims Office**
P.O. Box 14359 Lexington, KY 40512-4359	P.O. Box 14055 Lexington, KY 40512-4055

For claim payment inquiries or complaints, please call Provider Services at 855-281-6070, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

To learn more about Humana's payment policies, please visit Provider.Humana.com.

Common claim errors and reasons for denial or rejection

Common reasons for rejected or denied claims include the following:

- Enrollee or patient not found
- Missing or incorrect information
- Duplicate claim submitted
- Providers submitting with incorrect National Provider Identifier (NPI)/ZIP code/taxonomy/address/NPI type
- Missing provider NPI/ZIP code/taxonomy
- Rendering provider data missing for provider organizations
- Invalid HCPCS code submitted
- Billing/rendering/attending NPIs not enrolled/registered in CHAMPS
- NPI's not enrolled/registered in CHAMPS
- No prior authorization obtained for a service that requires one

You can avoid these common errors by doing the following:

- Confirming enrollee information received and submitted is accurate and correct
- Confirming enrollee eligibility with the HIDE-SNP plan on the date of service
- Ensuring all required claim form fields are complete and accurate
- Obtaining proper authorizations and/or referrals for services rendered.
- Ensuring you have a valid enrollee ID for the billing/rendering/attending NPIs and taxonomies submitted on claims exactly match the applicable active provider master list (PML) record

Humana's clearinghouse information—electronic data interchange

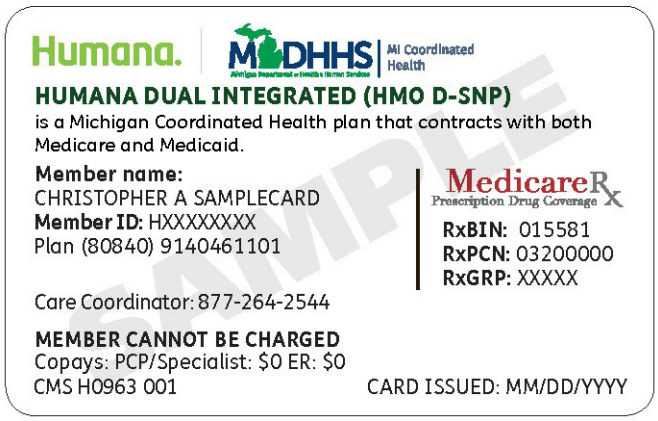
The following are some of the many clearinghouses offering services to healthcare providers. Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

Coverage type	Website	Phone number
Availity Essentials	https://www.availity.com/	800-282-4548
Optum for Business	https://www.changehealthcare.com/	800-792-5256

Coverage type	Website	Phone number
TriZetto®	https://www.cognizant.com/us/en/trizetto	800-556-2231
SSI Group	https://thessigroup.com/	800-820-4774
Humana ID		
Fee-for-service claims		61101
Encounter claims		61102

Enrollee ID cards

All new Humana enrollees receive an enrollee ID card. A new card is issued only if the information on the card changes, the card is lost, or an additional card is requested. The enrollee ID card is used to identify a Humana enrollee but does not guarantee eligibility or benefits coverage, as enrollees may disenroll from Humana or lose HIDE-SNP eligibility at any time. Therefore, it is important to verify enrollee eligibility prior to rendering services.



Notification of demographic changes

As a network provider, you are responsible for notifying Humana of demographic changes as outlined in the provider manual and under the terms of your contract.

Affected updates include demographic updates to your provider data or group status (e.g., service, mailing, billing address changes, demographic updates or providers roster changes).

To initiate demographic or roster updates (including a list of required documents), please visit the Join our network website.

After submission, a confirmation email and tracking number are provided. A contracting representative follows up to assist with next steps.

Immediate notification is required for:

- Demographic changes (e.g., telephone, fax, email or administrative staff changes)
- Name and ownership change (35-day notice)
- New enrollee indicator
- Physical address change

- Tax identification/billing address change (W-9 required)
- Provider added to existing group (The new provider still needs to follow the "Join our network" process.

For more information, please see the How to join our network section of the Humana Dual Integrated (HMO D-SNP) Provider Manual, found online at Provider.Humana.com/medicaid/michigandsnp/training.

This notification ensures your information is properly listed in the provider directory and all payments made are properly reported to the Internal Revenue Service. Failure to comply with this section may result in a delay in payment. If there are changes that affect your ability to provide services to our enrollees, please notify your Provider Relations representative immediately.

Provider training

Humana offers training materials to support providers' efforts to care for patients with HIDE-SNP coverage and to help meet state and federal compliance requirements. As a Humana provider, you are required to complete all necessary training identified in your contract during your initial Humana orientation. You also must ensure that your affiliated participating providers and staff members are trained using mandatory compliance materials.

Annual compliance training must be completed on the following topics as required by Section 6032 of the Federal Deficit Reduction Act of 2005, Humana's contract with the state and/or our compliance program:

- General compliance
- Combating fraud, waste and abuse
- Humana Dual Integrated (HMO D-SNP) provider orientation training
- Cultural humility, health equity and implicit bias
- Health, safety and welfare (abuse, neglect and exploitation) of enrollees

Providers and authorized users can access these online training modules 24 hours a day, 7 days a week via Availity Essentials at www.availity.com. Sign into Availity Essentials using your existing user ID and password. If you do not already have access to Availity Essentials, your organization's administrator may create a new user for this purpose. Once enrolled and logged in to Availity Essentials, the administrator should:

- Click on Payer Spaces > Humana > Humana Learning Center
- Select the category: Compliance training
- Search for the current year training by state (for any state(s) in which you are contracted).

Additional education and training are available to you at Humana.com/HealthyMI and through our continuing education (CE) program for medical and non-medical network providers via Relias – a web-based CE library. With more than 300 modules and more than 500 hours of CE credits available, the training modules in Relias provide integrated information to support comprehensive care and address unique enrollee needs.