

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 3 sections:

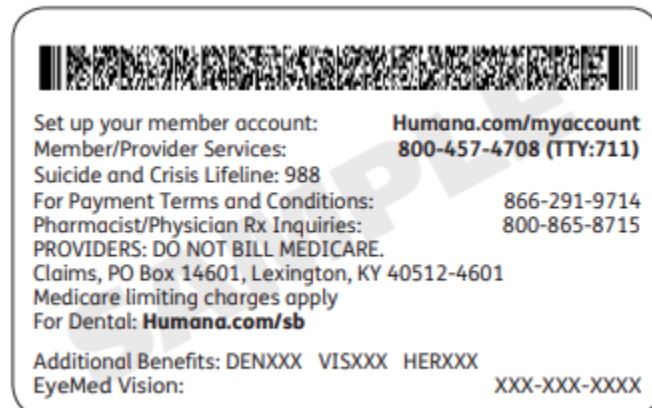
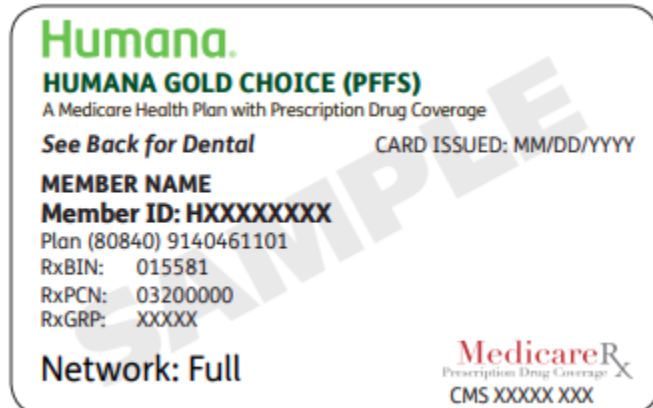
- General questions
- Reimbursement questions
- Operational guidelines



Humana

Humana PFFS member identification card information

Network: Full



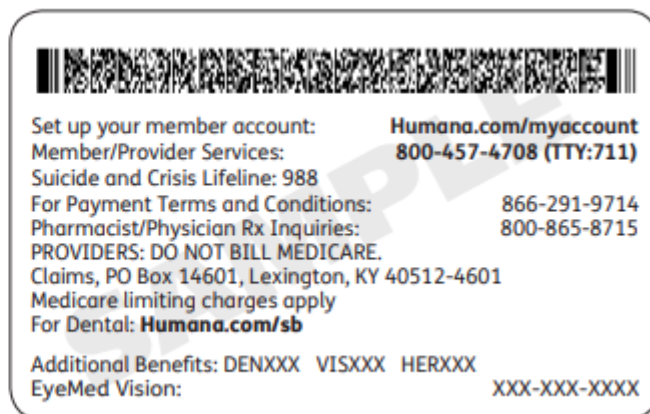
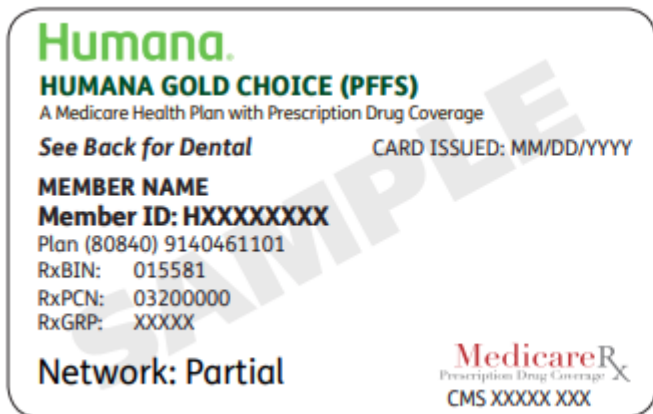
The Humana-covered patient who has this ID card is in a fully networked PFFS plan with both in-network and out-of-network PFFS benefits.

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 Provider.Humana.com > Working with Us> News & communications> Humana publications> Medicare provider materials and select "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- 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 Provider.Humana.com > Working with Us> News & communications> Humana publications> Medicare provider materials and select "Medicare Advantage PFFS plan model terms and conditions of payment."

General questions

Q: How are contracted network healthcare providers reimbursed?

A: Reimbursement is based on the contracted rate, which typically is a percentage of the Original Medicare rate. Healthcare providers should consult their contract for specific information and review Humana’s claim payment policies, available at Provider.Humana.com.

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 is the required format 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. Humana may assess an administrative fee for paper claim submission.

Submit paper claims to:

Humana MA PFFS
c/o Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Q: Are healthcare providers able to review claims status or verify patient eligibility online?

A: Yes. Healthcare providers who want to review claims or verify eligibility for their Humana MA PFFS patients can do so at www.availity.com. Providers can also call Customer Care at 800-457-4708.

Q: What options are available to healthcare providers who wish to dispute a payment?

A: The payment dispute process is included in the provider’s agreement. For more information, refer to the Humana Provider Manual found at Humana.com/Publications or view our presentation titled “Claim Disputes and Corrected Claims” found at Humana.com/MakingitEasier.

Q: Are healthcare providers able to correct claims or submit additional claims information online?

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

Q: Is advance coverage notification required for services that may not be covered under Humana’s 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 an 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. Providers also can call Humana Customer Care at 800-457-4708.

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. Healthcare providers should check their contracts or contact a provider contracting representative. They also can call Customer Care at 800-457-4708.

Q: How are payments for Full-Network outpatient hospital services determined?

A: The allowable amount for outpatient hospital services is based on contracted rates. Healthcare providers should check their contracts or contact a provider contracting representative. They also can call Customer Care at 800-457-4708.

Q: Are teaching hospitals eligible to receive the additional payment from Humana's MA Full Network PFFS plan that is provided by Medicare?

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 additions 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 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, is typically 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 Customer Care at 800-457-4708 for directions on providing that document to Humana.

Operational guidelines

Q: Are case management services available for Humana’s MA Full and Partial Network PFFS plans?

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 Provider.Humana.com or in the Provider Manual.

Q: What role does Humana play in discharge planning?

A: Humana case managers are available to support facility discharge planners with discharge planning when needed.

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 www.availity.com
- By calling Humana’s interactive voice response line at 800-523-0023

Q: Where can I access a list of services that require prior notification from Humana?

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 2 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 2 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 should I do if my question is not listed here?

A: Contact your Humana representative or call Humana’s Customer Care at 800-457-4708.