

# Physician/Facility FAQ Humana's Medicare Advantage (MA)

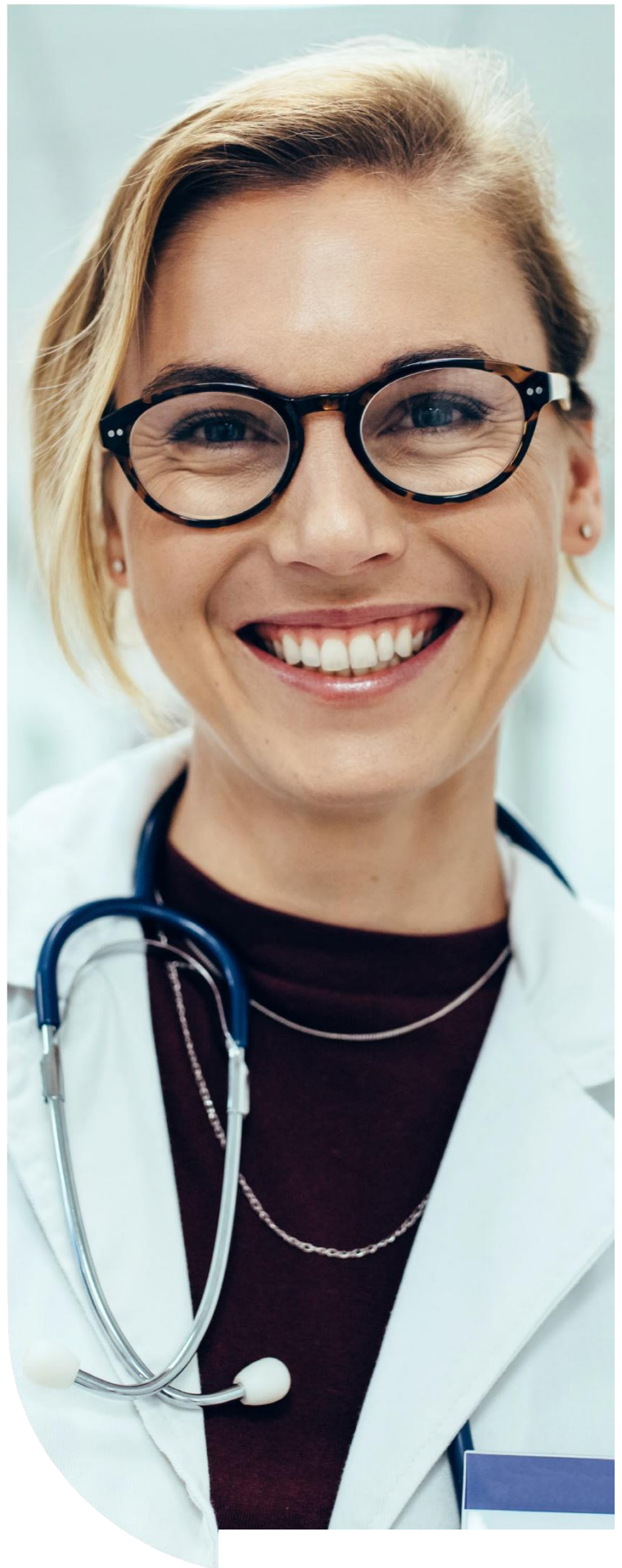
Preferred provider  
organization  
(PPO)

## HumanaChoice® PPO (Individual plan)

Humana created a collection of questions and answers for healthcare providers. They are divided into three sections:

- General questions
- Reimbursement questions
- Operational guidelines

# Humana



# Reminders for 2026

- Patients enrolled in Humana PPO plans are not required to select a primary care physician.
- Any healthcare provider participating in Humana MA PPO may see a patient with a HumanaChoice® PPO plan as an in-network provider.
- Healthcare providers do not need a referral to treat patients with a HumanaChoice® PPO plan.
- Patients with HumanaChoice® PPO plans may receive care from any Medicare healthcare provider.


## Individual MAPD PPO – No Dental

**Humana.**  
**HUMANACHOICE (PPO)**  
A Medicare Health Plan with Prescription Drug Coverage

CARD ISSUED: MM/DD/YYYY

**MEMBER NAME**  
**Member ID: HXXXXXXXXX**  
Plan (80840) 9140461101  
RxBIN: 015581  
RxPCN: 03200000  
RxGRP: XXXXX

**MedicareRx**  
Prescription Drug Coverage  
CMS XXXXX XXX



Set up your member account: **Humana.com/myaccount**  
Member/Provider Services: **800-457-4708 (TTY:711)**  
Suicide and Crisis Lifeline: 988  
Pharmacist/Physician Rx Inquiries: 800-865-8715  
Claims, PO Box 14601, Lexington, KY 40512-4601

Medicare limiting charges apply  
For Dental: **Humana.com/sb**

Additional Benefits: VISXXX HERXXX  
EyeMed Vision: XXX-XXX-XXXX


## Individual MAPD PPO

**Humana.**  
**HUMANACHOICE (PPO)**  
A Medicare Health Plan with Prescription Drug Coverage

**See Back for Dental** CARD ISSUED: MM/DD/YYYY

**MEMBER NAME**  
**Member ID: HXXXXXXXXX**  
Plan (80840) 9140461101  
RxBIN: 015581  
RxPCN: 03200000  
RxGRP: XXXXX

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Claims, PO Box 14601, Lexington, KY 40512-4601

Medicare limiting charges apply  
For Dental: **Humana.com/sb**

Additional Benefits: DENXXX VISXXX HERXXX  
EyeMed Vision: XXX-XXX-XXXX


## Individual MAPD PPO D-SNP

**Humana.**  
**HUMANACHOICE (PPO D-SNP)**  
A Medicare Health Plan with Prescription Drug Coverage

**See Back for Dental** CARD ISSUED: MM/DD/YYYY

**MEMBER NAME**  
**Member ID: HXXXXXXXXX**  
Plan (80840) 9140461101  
RxBIN: 015581  
RxPCN: 03200000  
RxGRP: XXXXX

**MedicareRx**  
Prescription Drug Coverage  
CMS XXXXX XXX



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Pharmacist/Physician Rx Inquiries: 800-865-8715  
Claims, PO Box 14601, Lexington, KY 40512-4601

Medicare limiting charges apply  
For Dental: **Humana.com/sb**

Additional Benefits: DENXXX VISXXX HERXXX  
EyeMed Vision: XXX-XXX-XXXX

# General questions

## **Q: How are contracted 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](http://Provider.Humana.com).

## **Q: How are non-contracted healthcare providers reimbursed?**

**A:** Non-contracted healthcare providers are reimbursed according to Original Medicare's fee schedule for the area.

## **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 PPO plan and returns to Original Medicare, how are the patient's cost shares calculated?**

**A:** If a patient disenrolls from the Humana MA PPO plan and returns to Original Medicare, then Original Medicare cost-sharing provisions would apply.

## **Q: If a patient disenrolls from Humana's MA PPO 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. The directory can be found at [Humana.com/FindADoctor](http://Humana.com/FindADoctor).

## **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 patients covered by Humana MA PPO plans can do so at [www.availity.com](http://www.availity.com). Providers also can call Customer Care at 800-457-4708 for assistance.

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

**A:** The payment dispute process is included in the Humana Provider Agreement. For more information, refer to the Humana Provider Manual found at [Humana.com/Publications](http://Humana.com/Publications) or view our presentation titled "Claim Disputes and Corrected Claims" found at [Humana.com/MakingitEasier](http://Humana.com/MakingitEasier).

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

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

## **Q: What is the required format for claims?**

**A:** Use the same format used for Original Medicare. Humana's MA PPO plans accept paper and electronic claims in 837I (Institutional) or 837P (Professional) format.

To decrease administrative costs and improve cash flow, clinicians and facilities are encouraged to use electronic claims submission whenever possible. Humana may assess an administrative fee for paper claim submission. When it is necessary to submit paper claims, please use the address below. Keep in mind, however, that the claim or encounter mailing address on the patient's Humana member ID card is always the most appropriate to use.

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

## **Q: Is advance patient notification required for services that may not be covered under Humana's MA PPO plan?**

**A:** Regardless of whether Humana requires prior authorization for a particular item or service, when the healthcare provider thinks a service might not be covered, he or she 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-1003 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 as if the service were coverable. That is, the provider must not balance bill an MA PPO-covered patient 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, see Chapter 4, Section 160, of the Medicare Managed Care Manual.

**Q: What does PPO SNP mean on the patient's ID card?**

**A:** The addition of SNP means the patient is enrolled in a Special Needs Plan (SNP). It is a PPO plan with extra benefits for patients with special healthcare needs. Benefit and eligibility information is available at [www.availity.com](http://www.availity.com). Healthcare providers also can call the member/provider service number on the back of the patient's Humana ID card.

SNP training is required for any provider who sees a Humana MA plan member covered by any of our SNPs. Please visit [Humana.com/ProviderCompliance](http://Humana.com/ProviderCompliance) to complete your training today.

Please note: Federal law prohibits balance billing of cost-share protected (CSP) members. You can determine if a member is CSP by visiting [www.availity.com](http://www.availity.com).

If a member is enrolled in a Humana Chronic condition SNP (C-SNP), please make sure the Verification of Chronic Condition form is completed within 60 days of enrollment. You can visit [www.availity.com](http://www.availity.com) and submit an Eligibility and Benefits inquiry for the member and select the C-SNP Condition Verification button on the response to complete this form.

Providers can call 877-271-5776 for additional information.

# Reimbursement questions

## **Q: How are payments for inpatient hospital services determined?**

**A:** The allowable amount for inpatient hospital services is based on contracted rates. These rates typically are a percentage of the Medicare Severity-Diagnosis Related Group (MS-DRG) payment system, less certain MS-DRG components that HumanaChoice® PPO might not pay. See the applicable contract for each facility for details.

## **Q: How are payments for 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 800-457-4708.

## **Q: Are teaching hospitals eligible to receive the additional payment from Humana’s MA PPO plan that is provided by Medicare?**

**A:** No. Humana’s MA PPO 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 add-ons to providers directly through its CMS Medicare Administrative Contractors (MAC) for Parts A and B or Durable Medical Equipment 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 MA PPO plans?**

**A:** No. CMS does not require MSPs for patients with MA. However, hospitals should have their patients fill out the MSP questionnaire. Humana reimburses healthcare providers and attempts to recover money from any third party that might be liable after the fact.

## **Q: What is an “essential hospital?”**

**A:** The Medicare Modernization Act includes provisions designed to increase beneficiary hospital choice in rural areas by providing structure and incentives that will broaden health plan service areas. The designation “essential hospital” is given to a hospital by the regional PPO and approved by CMS. If your hospital has been notified by CMS that it is designated as an “essential hospital” and you have further questions, please call Customer Care at 800-457-4708.

## **Q: How are rural health clinics and critical access hospitals reimbursed?**

**A:** Medicare reimburses rural providers using a methodology other than the Prospective Payment System (PPS) standard for Medicare, and we take 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 us.

# Operational guidelines

## **Q: Does Humana’s MA PPO follow all Medicare rules for readmissions?**

**A:** Yes. Humana’s MA PPO follows all Medicare rules for readmissions.

## **Q: What are the guidelines for enrollment and disenrollment?**

**A:** CMS determines enrollment and disenrollment guidelines. Please visit the CMS website at [www.CMS.gov](http://www.CMS.gov) for more information.

## **Q: Are hospitals permitted to collect copayment amounts prior to providing services?**

**A:** Yes. Hospitals can request the copayment up front and/or at the time of discharge.

## **Q: Are case management services available for Humana’s MA PPO plans?**

**A:** Telephonic case management is available to Medicare Advantage HMO, PPO, and Private Fee-For-Service (PFFS) plans. Case management programs and how to refer members to the programs can be found at [Humana.com/Provider](http://Humana.com/Provider) or in the Provider Manual.

## **Q: What kind of criteria does Humana’s MA PPO use for medical necessity?**

**A:** Humana’s MA PPO plans use Medicare coverage guidelines, nationally accepted guidelines (such as MCG), and peer-reviewed literature to determine medical necessity.

## **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: Where can I find a list of services requiring prior authorization?**

**A:** The full list of prior authorization and notification requirements applies to Humana MA PPO-covered patients. Prior authorization is required for in-network inpatient admissions (except urgent or emergent) and some outpatient procedures. The prior authorization and notification list are located at

[Humana.com/PAL](http://Humana.com/PAL).

Prior authorization requests and notifications for medical services can be initiated:

- Online at [www.availity.com](http://www.availity.com)
- By calling Humana’s interactive voice response line at 800-523-0023
- Providers are encouraged to include any medical records to support your request at the time you are submitting your prior authorization.

## **Q: Does Humana’s MA PPO 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 hospitals provide and explain to all MA beneficiaries the standardized notice titled “Important Message” (IM) within two calendar days of admission and obtain the signature of the beneficiary or the beneficiary’s representative. The signed copy can 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 access to 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 not more than two 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 who is 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.