Humana Healthy Horizons in South Carolina Claims Payment Inquiry Resolution and Service Information

Humana Healthy Horizons® in South Carolina would like to share some details about our claim payment inquiry process and examples of covered, non-covered and excluded services. If you have questions, please call Provider Services at **866-432-0001**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

What to expect when making a claims payment inquiry

First inquiry

Call us at **866-432-0001**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time. We can answer your claims questions and connect you to the right resource when further review or research is needed. During your call, we will give you a reference number. We encourage you to write it down, so you can refer to it if needed.

- If we ask you to submit a corrected claim, please do not submit medical records, as this will delay payment consideration of your claim.
- If our call center associate cannot answer your question(s) to your satisfaction, you can ask for a supervisor. Based on availability, you may be immediately connected to a supervisor or one will return your phone call within 48 hours.
  - If this telephonic outreach is your first attempt resolve your dispute, please give us enough time to research the issue before reaching back out to us. We will follow the time specifications outlined in sections 9.2.10 and 9.2.12 of the South Carolina Department of Health and Human Services (SCDHHS) contract.
    - Generally, we respond to inquiries within 30 calendar days. If we are unable to provide a response in that timeframe, we may request up to a 15-calendar-day extension. If you agree to the extension, we will continue to work on your dispute and provide a resolution within, but not to exceeding, 45 calendar days.
- In some situations, we may route your question(s) to a Humana Healthy Horizons internal team. If we think this is the right course of action to resolve your question(s), we will notify you in writing and/or send you an updated explanation of remittance based on all additional review/research we undertake on your behalf.

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Second inquiry

- If you disagree with our initial determination and want to dispute it, you can escalate your concern by emailing **HumanaProviderServices@humana.com**. Include with your email:
  - Reference number(s) associated with previous attempt(s) to resolve the inquiry
  - The healthcare provider's name and Tax Identification Number (TIN)
  - The Humana Healthy Horizons member's ID number
  - The date of service, claim number and name of the provider of the services
  - The charge amount, actual payment amount, expected payment amount and a description of the basis for the contestation
  - Contact information for our response
- We will send an Acknowledgement of Submission email with a submission tracking number within 5 business days of your submission.
- Please allow between 30 and 45 days from the date on the Acknowledgement of Submission for our response.

South Carolina claims code editing rules

Submit code-edit questions and access simulations online. Humana's "Submit code edit questions" tool and Code Edit Simulator are available online through Availity Essentials. Please note that to use these tools, you will need to register at **Availity.com**.

To submit code-edit questions

1. Sign in to Availity Essentials and select "Payer Spaces," then "Humana."
2. Select "Research Procedure Code Edits" from the list of applications.
3. Use the application to submit your procedure code-edit question.

To run code-editing simulations

1. After logging in to Availity Essentials, select "Payer Spaces" in the top navigation bar, then select "Humana."
2. Under the Applications tab, select "Code Edit Simulator." If you do not see the Code Edit Simulator, contact your Availity Essentials administrator to request access.

Payment integrity general inquiries and escalation process

Please reference the following guidance when submitting provider payment integrity (PPI) inquiries about medical record reviews, including medical record requests and recoupment due to overpayment, or to escalate a PPI-related concern.

If you disagree with medical record review findings or have questions about an overpayment, you can manage inquiries electronically with the **Availity Essentials overpayment application** under "Claims & Payments." Don't have a secure Availity Essentials account? **See how to create one**.

After registering:

- Find helpful resources on how to use Availity Essentials tools and features through the "Help & Training" menu on the main navigation bar.

- For help with technical website issues, call Availity Client Services at **800-AVAILITY (282-4548)**.

You also can call us at **800-438-7885**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time, and a representative can help. When calling, please make sure to have:

- Patient name and date of birth
- Humana Healthy Horizons member ID number
- Date(s) of service
- Claim number
- Healthcare provider's name
- Provider's TIN
- Recovery identification number
- Reason for your inquiry
- Contact person's name, email, mailing address, phone number and best time to call

A Humana PPI customer care representative will research your question and respond within 7 to 10 business days. During your call, we will provide a reference number. We encourage you to write it down, so you can reference it if needed.

If you are dissatisfied with our response, or believe it fails to resolve your concerns, you can escalate your PPI inquiry by sending a secure email to **HelpPPI@humana.com**.

Please note: The subject line of your email should include the reference number(s) you received during your initial contact. Your email should include the information in the bulleted list above and:

- The charge amount, actual payment amount and expected payment amount
- A description of the basis for the dispute

The Escalations Team will research your question and respond within 3 to 7 business days.

To submit a medical record review dispute, please review the **associated policy and use the provided form**.

Points of contact for inquiries and appeals

Please submit all requested material records in response to PPI requests via your secure **Availity Essentials account**. You must create an account before you can use Availity Essentials to submit information.

How to avoid claims submission errors

Common reasons for rejection or denial:

- Incorrect National Provider Identifier (NPI)/ZIP code/taxonomy code
- Encounters missing NPI/ZIP code/taxonomy code
- Encounters without a billing/rendering/referring/ordering NPI or one that is not enrolled/registered for Medicaid with SCDHHS
- Encounters with zero-dollar billed charges
- Providers submitting a claim form (1500/UB) that is not appropriate for their registered provider type
- Incorrect encounter payer ID

Where to send paper claims and encounters

Though we prefer to receive electronic claims and encounters via your secure Availity Essentials account, you can submit claims and encounters via direct mail:

Paper claims mailing address
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Paper encounters mailing address
Humana Encounters
P.O. Box 14605
Lexington, KY 40512-4605

Covered services

Humana Healthy Horizons, through our contracted healthcare providers, is required to arrange for our members, when medically necessary, the following services:*

Abortions (coverage only with documentation of rape, incest or pregnancy endangering the woman's life)	Independent laboratory and X-ray services
Ambulance transportation for out-of-state medical services	Inpatient hospital services
Ancillary medical services	Institutional long-term care facilities/nursing homes
Audiological services	Maternity services
Behavioral health services	Outpatient services
Chiropractic services, limited to manual manipulation of the spine to correct a subluxation	Pharmacy/prescription drugs
Communicable disease services	Physician services
Durable medical equipment	Rehabilitation therapies for children (non-hospital based)
Early and Periodic Screening, Diagnosis and Treatment/well-child visits	Sterilization services
Emergency/post-stabilization services	Substance abuse
Family-planning services	Telehealth services
Home health	Transplant and transplant-related services
Hysterectomies	Vision services (limited to members 21 and younger)

* See member certificate of coverage for full coverage details.

Services not covered

South Carolina Medicaid only pays for medically necessary services. The following is a non-inclusive list of services for which South Carolina Medicaid does not pay, including examples of service limitations, exclusions from coverage, and moral or religious objections:

Abortion (unless the mother's life is in danger, or in the case of incest or rape)	In-vitro fertilization
Braces for teeth, dentures, partials and bridges for members 21 and older	Massage and hypnosis
Cosmetic surgery	Paternity testing
Fans, air conditioning, humidifiers, air purifiers, computers, home repairs	Services from healthcare providers who are not part of the Humana Healthy Horizons network
Fertility drugs	Services not covered (including those listed)
Hearing aids for members 21 and older	Services that are not medically necessary
Hospital stays for services that can be treated outside the hospital	Unauthorized services
Hysterectomy for sterilization purposes	

Excluded services

The current South Carolina Medicaid program continues to provide and reimburse for the following services, consistent with the outline and definition of covered services in the Title XIX South Carolina Medicaid Plan:

- Medical (non-ambulance) transportation
- Broker-based transportation (routine non-emergency medical transportation)
- Dental services
- Targeted case management services
- Home-and community-based waiver services
- Medicaid Adolescent Pregnancy Prevention Services family-planning services
- Developmental evaluation services

Payment for these services will remain Medicaid fee-for-service. Managed care organizations (MCOs) are expected to be responsible for the continuity of care for all Medicaid MCO members by ensuring appropriate service referrals are made for the Medicaid MCO member for excluded services.