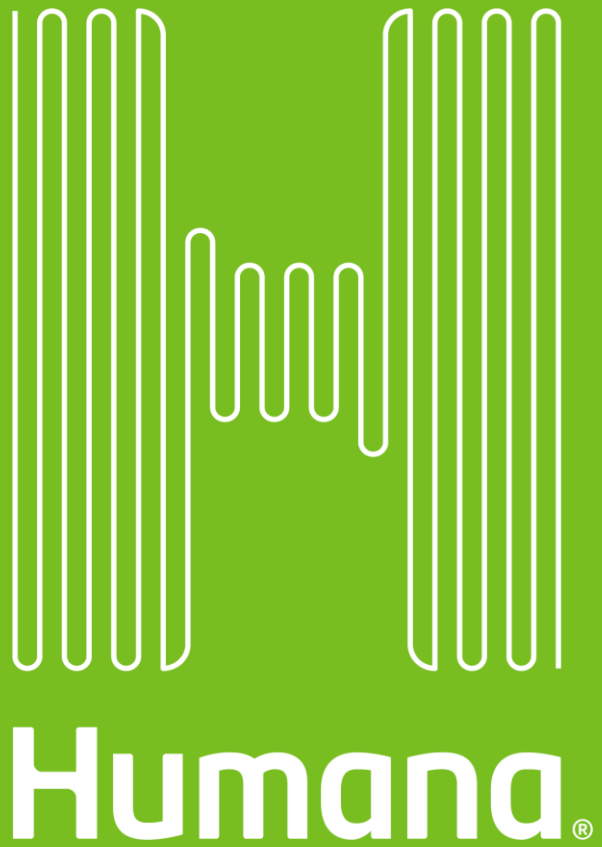

Humana Orientation Training

Information for dual Medicare-Medicaid healthcare providers and administrators

January 2023
Illinois

132502IL1222--A (ILHLTRDEN)

Notable changes for 2023

This 2023 version does not include significant changes from the 2022 version.

Training topics

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Training topics

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Training topics are based on the following:

- Humana's contract with the Illinois Department of Healthcare and Family Services
- Humana's policies and procedures

Humana.

Illinois Medicare-Medicaid Alignment Initiative (MMAI)

About Humana

- Insurance products
- Health and wellness services
- $39 billion in annual revenues
- 50,000 employees
- Plans for employer groups, individuals and government agencies
- Commercial, Medicare and Medicaid (in select markets)
- Plans include health, dental, vision and behavioral health
- 14.3 million medical members
- 7 million specialty members

General information

Aid to the aged, blind and disabled (AABD) members:

- The Medicare-Medicaid plan (MMP) includes benefits for AABD members 21 and older.

Medicare-Medicaid-eligible deductible/coinsurance:

- Healthcare providers cannot collect coinsurance, copayments, deductibles, financial penalties or any other amount, in full or part, for any service provided under this contract.

General information (cont'd)

Patient enrollment/disenrollment:

- MMAI-eligible individuals can enroll and disenroll at any time by contacting the Illinois Client Enrollment Services team at:
  - 877-912-8880
  - TTY: 866-565-8576

Timely filing:

- Humana shall not deny claims for services delivered by providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds 365 calendar days.

Medicare-Medicaid Plans (MMP)MMP

Purpose of Medicare-Medicaid plans

The purpose of the plan is to integrate benefits and improve coordination between the federal government and states. The model brings together primary care physicians (PCPs), specialists, hospitals and a wide variety of other providers who will focus on the health, behavioral health, long-term services and supports and the social needs of Medicaid clients.

Purpose of Medicare-Medicaid plans (cont'd)

Key objectives are to:

- Improve the patient's experience in accessing and receiving person-centered care
- Improve the quality of healthcare and long-term services
- Improve care coordination and access to enhanced services
- Improve the quality performance of providers and suppliers of services
- Reduce costs for the state and federal government
- Promote independence in the community

To support these objectives, every MMP-enrolled member has access to and is assigned a care coordinator to complete a comprehensive assessment and identify member goals and care needs. The coordinator also works with the member to develop an individualized care plan, support provider treatment plans and encourage members to maintain appointments.

MMP access-to-care requirements

Participating PCPs and specialists are required to ensure adequate accessibility for healthcare 24 hours a day, seven days a week and shall not discriminate against members. An after-hours telephone number must be available to members (voicemail is not permitted).

Members should be triaged and provided appointments for care within the following time frames:

- **Urgent care**

  A member must be provided an appointment within 24 hours.
- **Routine sick member care**

  A member shall be seen within three weeks from the date of the request.

MMP access-to-care requirements (cont'd)

- **Well-care and routine visits**

  Appointments for routine, preventive care should be available within five weeks from the date of the request.

- **Initial prenatal visits without expressed problems**
  - **Presenting in first trimester**—Member must be provided an appointment within 14 calendar days of the request.
  - **Presenting in second trimester**—Member must be provided an appointment within seven calendar days of the request.
  - **Presenting in third trimester**—Member must be provided an appointment within three calendar days of the request.

  Non-emergent transportation service is provided by MTM Inc. (Details on MTM appear later in this presentation).

Long-term services and support (LTSS)

Long-term services and support (LTSS)

Long-term services and support (LTSS) provides long-term care in a nursing facility, or home and community-based services (HCBS) to members. HCBS services can include personal care assistance, emergency medical alert button accessibility and home-delivered meals.

Five HCBS waiver types are managed within the Illinois MMAI program: Elderly (60 and older), physically disabled (younger than 60), brain injury, HIV/AIDS and supported-living facility.

LTSS (cont'd)

- A member, family member or provider may request a state assessment for LTSS eligibility.
- To be considered for LTSS eligibility, the member must have long-lasting or chronic self-care deficits that qualify for nursing facility level of care.
- LTSS eligibility is determined by the state.
- After state approval, Humana will send a care coordinator to the member's home to determine functional needs, develop an individualized care plan and initiate a LTSS service plan.

LTSS (cont'd) – covered services

Care coordinators work with members to determine type and duration of necessary waiver services, including:

- Specialized medical equipment and supplies
- Adult day services and transportation
- Behavioral services
- Day habilitation services
- Home health aide
- Homemaker
- Environmental accessibility adaptions
- Supported employment
- Supported living facilities
- Home-delivered meals
- Personal assistant
- Personal emergency response system
- Prevocational services
- Respite
- Nursing – intermittent
- Nursing – skilled
- Extended plan therapy services (physical, occupational, speech)

Behavioral health

Behavioral health clinical management program (Beacon Health Options)

Humana contracts with Beacon Health Options to delegate behavioral health functions including, but not limited to:

- Provider network contracting and credentialing
- Quality management
- Care coordination
- Utilization review/medical management
- Member services
- Claims processing and payment

Beacon contact information

- Behavioral health providers can find information on Beacon's provider portal at www.beaconhealthoptions.com/providers
  or via the following options:
  - **Email:** SoutheastServiceCenterPR@BeaconHealthOptions.com
  - **Interactive Voice Recognition (IVR):** 855-481-7044
    - Check member eligibility, claims status and authorization status
    - Plan to provide your practice or organization Tax Identification Number (TIN), the member's ID number, member's date of birth and the date of service.
  - **Claims hotline:** 855-481-7044

Beacon contact information (cont'd)

Beacon's IVR line, 855-481-7044, connects providers to the following services:

- Provider relations
- Clinical staff

Beacon eServices

- EDI/electronic claims
  - For an EDI companion guide, please email edi.operations@beaconhealthoptions.com.

Credentialing and contracting

Credentialing

Before treating Humana members, healthcare providers must be credentialed. Please reference the Humana MMAI Provider Manual for further details.

All Illinois MMAI network providers:

- Must be credentialed by the state via the IMPACT system prior to their contract effective date with Humana
- Be recredentialed as the state requires

Please note: General provider credentialing requirements can be found at the state's IMPACT website: www.illinois.gov/hfs/impact/Pages/default.aspx.

In addition to good standing with Medicare, federal, state and local agencies, healthcare providers must be free from active Illinois Department of Healthcare and Family Services (IHFS) sanctions.

Requesting a CAQH ID

If not registered with CAQH, please complete the process by visiting proview.caqh.org/PR/Registration.

Once the registration is submitted, you will receive an email containing a CAQH provider ID. You will then need to complete the online application and grant Humana authorization to review/receive your information.

Contracting process—required information

- Physician, practice/facility name
- Service address, phone, fax and email information
- Mailing address (if different than service address)
- Specialty
- Medicaid provider number
- National Provider Identifier (NPI)
- CAQH number
- Lines of business (e.g., Medicare Advantage)
- Contract type (e.g., individual, group, facility)

Contracting/credentialing contacts

Medical provider contracting requests:

- Visit **Humana.com/providers**.
- Choose “Join Our Network.”
- Choose “Contracting with Humana.”
- Complete online form.

Credentialing status:

- To check credential or contract status, please call Humana Provider Relations at 800-626-2741. Hours of operation are Monday through Friday, 8 a.m. to 5 p.m., Central time.

Contracting/credentialing contacts (cont'd)

Long-term services and support providers contracting requests:

- Illinois providers can call 800-626-2741. Hours of operation are Monday through Friday, 8 a.m. to 5 p.m., Central time.

Behavioral health providers (Beacon) contracting requests:

- Behavioral services providers can contact Beacon Health Options provider relations for network contracting and credentialing.
- Illinois providers can call 855-481-7044.

Web resources

Provider website – public

Humana.com/providers

- Health and wellness programs
- Clinical practice guidelines
- Provider publications (including state-specific Humana provider manual appendices) at **humana.com/provider/medical-resources/illinois-medicaid**
  Pharmacy services
- Claim resources
- Quality resources
- What's New
- Webinars—visit **Humana.com/ProviderWebinars** to register

Working with Humana online? Use multi-payer Availity Essentials

Availity Essentials is Humana's preferred method for online transactions.

- ✓ Use one site to work with Humana and other payers
- ✓ Check eligibility and benefits
- ✓ Submit referrals and authorizations
- ✓ Submit claims and check claim status
- ✓ Use Humana-specific tools

How to register

- Go to Availity.com and click the Register button.

Join us for a training session

- Visit to learn about training opportunities and reserve your space.

Questions?

- Availity Essentials helps with registration and tools:
  Call 800-AVAILITY (800-282-4548)

About Availity Essentials

- Co-founded by Humana in 2001
- Humana's clearinghouse for provider electronic transactions (EDI)

Preauthorization and notification

Preauthorization and notification

- Required for many services and medications
- Access lists at **Humana.com/PAL**
  - Select the current “Medicare Advantage and Medicare-Medicaid Plans Preauthorization and Notification List”

Preauthorization for medical procedures

- Call 800-523-0023 (available 24 hours a day, seven days a week) for automated requests.
- Representatives available Monday through Friday, 7 a.m. to 7 p.m., Central time (excluding major holidays).
- Press “0” or say “representative” for live help.
- Have TIN available.
- To view the preauthorization list, visit **Humana.com/PAL** and choose the current “Medicare Advantage and Dual Medicare-Medicaid Plans Preauthorization and Notification List.”

Drug prior authorization and notification

- Get forms at **Humana.com/pa** or call 800-555-2546.
  Hours of operation are Monday through Friday, 7 a.m. to 5 p.m., Central time.
- For drugs delivered/administered in physician's office, clinic, outpatient or home setting:
  - **Humana.com/MedPA**
  - 866-461-7273 (Hours of operation are Monday through Friday, 7 a.m. to 5 p.m., Central time)

Claims processing

Paper claims

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

Medical claims
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Behavioral health
Beacon Health Options
P.O. Box 1866
Hicksville, NY 11802-1866

LTSS
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Encounters
Humana Claims Office
P.O. Box 14605
Lexington, KY 40512-4605

Submission requirements

- Healthcare providers are required to file claims/encounters on time for all services rendered to members. Timely filing is an essential component reflected in Humana's Healthcare Effectiveness Data and Information Set (HEDIS®) reporting. It ultimately affects how a plan and its providers are measured in preventive member care and screening compliance.

- Fee-for-service claims should be filed as soon as possible and no later than 12 months post-service.

- Encounter claims should be filed within 30 days.

- Behavioral health claims should be filed within 180 days, or 60 days from the primary insurance remittance date in cases of coordination of benefits.

Payer IDs

When filing an electronic claim, use one of the following payer IDs:

- **61101** for fee-for-service claims (non-capitated)
- **61102** for commercial encounter claims (capitated)
- **61105** for delegated encounter claims (Illinois only)
- **43324** for behavioral health claims (Beacon)

Electronic claim submission

CLAIMS CLEARINGHOUSES:*		
Availity Essentials**	www.Availity.com	800-282-4548
Change Healthcare	www.changehealth.com	888-363-3361
TriZetto	www.trizettoprovider.com	800-969-3666
SSI Group	www.thessigroup.com	800-820-4774

* Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

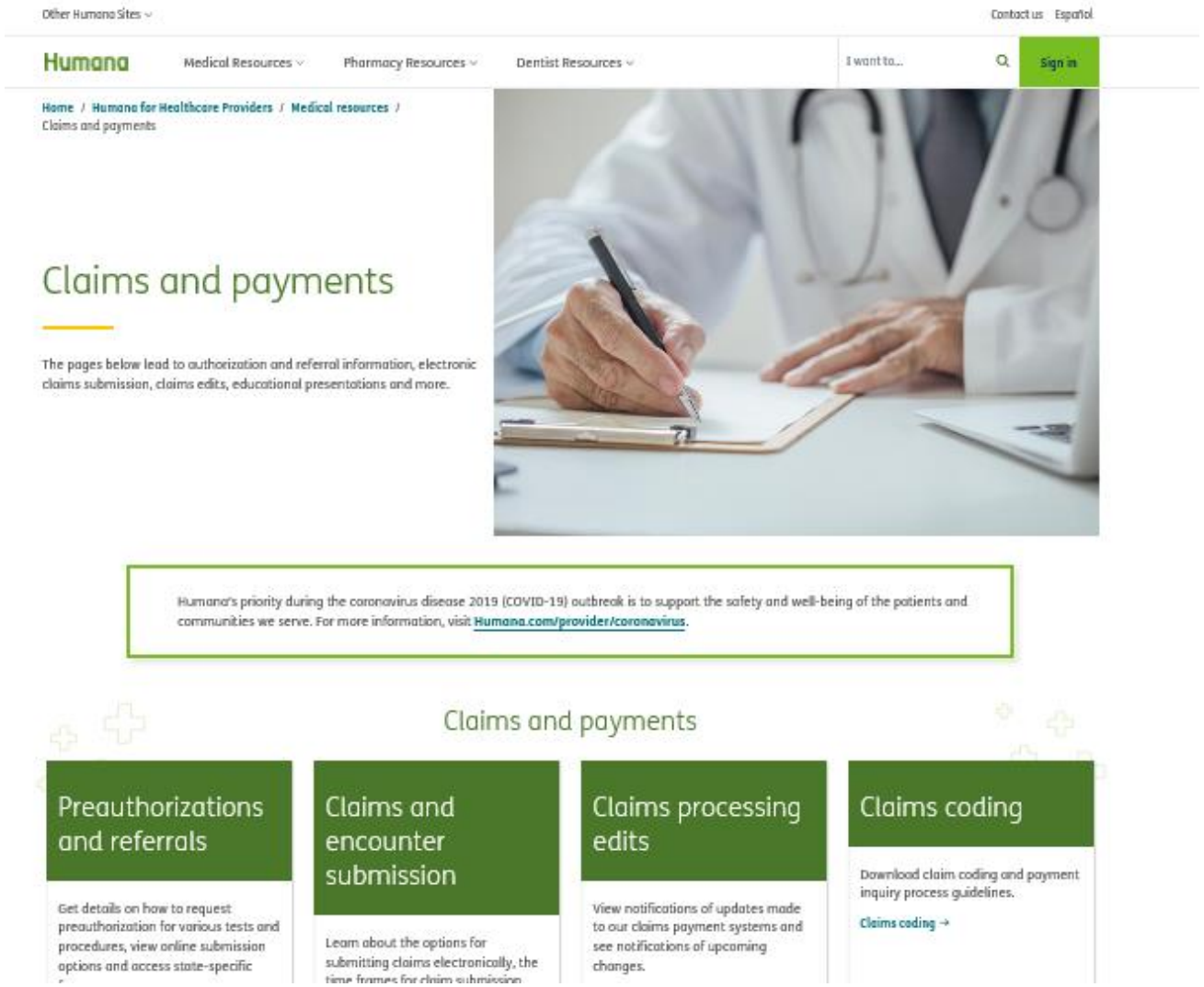
** Availity Essentials is Humana's preferred clearinghouse, and there are no service fees when electronic claims are submitted for Humana-covered patients.

Claims information on Humana.com

Locate information about:

- Electronic claims submission
- Claim coding guidelines
- Claim processing edits

Go to **Humana.com/ClaimResources**



Claims status and edit questions

Online management (registration required)

- Access 18 months of claims history
- View claims details
- Export your search results
- Correct claims online
- Add attachments
- View 835 remittance advice
- Download HIPAA X12 formats
- Access the Code Editing Simulator tool to receive instant response about code edits that may be applied

To access this information, sign in to the secure provider portal at Availity.com.

Claim inquiry escalation steps

Step 1:

Call 800-787-3311, Monday through Friday, 7 a.m. to 7 p.m., Central time.

- Have the claim reference number handy.
- Note the call reference number issued to you by the provider call center representative, as it may be needed in the future.
- If your issue is still outstanding and has not been adequately addressed by the call center representative, you have the option to speak to a call center supervisor. Based on availability, you will be connected to a supervisor, or a supervisor will contact you within 48 hours of your request.

OR

Submit a written claim dispute via:

Mail to: Humana Provider Correspondence
P.O. Box 14601
Lexington, KY 40512-4601

Fax to: 888-556-2128

Claim inquiry escalation steps

Step 2: If we respond to your initial inquiry and there is a factual disagreement with the response, you can send a secured email (with the reference number) to **HumanaProviderServices@humana.com**.

For more information, please visit **www.humana.com/provider/medical-resources/claims-payments/claims-payment/payment-inquiries**.

How to avoid common claims submission errors

Common rejection or denial reasons:

- Patient not found
- Insured subscriber not found
- Patient birthdate on the claim does not match the date of birth (DOB) found in our database
- Missing or incorrect information
- Submission of an invalid Healthcare Common Procedure Coding System (HCPCS) code
- No authorization or referral found

How to avoid these errors:

- Ensure accuracy of patient information received and submitted
- Ensure completion and accuracy of all required claim form fields
- Obtain proper authorizations and/or referrals for rendered services

Claims payment: Electronic funds transfer (EFT) and electronic remittance advice (ERA)

- Receive Humana payments via direct deposit into the bank account of your choice
- Get paid up to seven days faster than via mail
- Reduce lost or stolen check risk
- Receive HIPAA-compliant ERA transactions
- Have remittances sent to your clearinghouse or view them online
- Reduce paper mail and time spent on manual processes

Contact us if your organization needs …

Payments deposited into more than one bank account

Separate remittance information for different providers or facilities

ERA/EFT setup for multiple provider groups, facilities and/or individuals

Balance billing

Per Humana's provider manual:

Services that are not medically necessary: The provider agrees that, in the event Humana issues a payment denial for rendered services to a member due to lack of medical necessity, the provider shall not bill, charge, seek payment or have any recourse against the member for such services.

Clinical management programs

Clinical management programs

Designed to:

- Reinforce medical provider's instructions
- Promote healthy living
- Provide guidance to members with complex conditions

To learn more, visit **Humana.com/HealthWellness**.

Medical Transportation Management (MTM)

MTM provides non-emergency transportation for:

- Medical appointments
- Nursing home visits
- Pharmacy trips (immediately after physician visits)
- Medical provider appointments at other locations
- Ongoing care, such as dialysis

Depending on medical conditions and locations, member transportation may include taxi, bus, van, subway, wheelchair vehicle, stretcher van or medical transport.

Curb-to-curb service is provided. Transportation drivers may not enter homes or medical facilities.

MTM (cont'd)

- If medically necessary, one escort (18 or older) is allowed to accompany a member when space is available.
- When possible, transportation should be scheduled at least three days in advance by calling 855-253-6867. Phone line hours of operation are Monday through Friday, 8 a.m. to 8 p.m., Central time.
- When trips cannot be scheduled in advance (such as return trips from medical appointments), members may still call MTM at 855-253-6867.
- TTY users may dial 711 to access the local provider.

MTM (cont'd)

- Members also can schedule via the MTM member portal, 24 hours a day, seven days a week at Memberportal.net/
- Providers can help members schedule trips via the MTM facility portal by visiting smp.mtm-inc.net/.

Helpful numbers

Helpful numbers

Medicare and Medicaid customer service
Please call the number on the back of the member's ID card for the most efficient call routing.

Preauthorization (PA) assistance for medical procedures
800-523-0023 (Monday through Friday, 8 a.m. to 8 p.m., Eastern time)

PA for medication billed as medical claim
866-461-7273 (Monday through Friday, 8 a.m. to 6 p.m., Eastern time)

PA for pharmacy drugs
800-555-2546 (Monday through Friday, 8 a.m. to 6 p.m.)

Helpful numbers (cont'd)

Provider relations (answering as Health Planning and Support)
800-626-2741 (Monday through Friday, 8 a.m. to 5 p.m., Central time)
(fee schedule requests, demographic changes and credentialing status)

Medicare/Medicaid case management
800-322-2758

Medicare/Medicaid concurrent review
800-322-2758

Clinical management program information
800-491-4164

CenterWell Pharmacy™
800-379-0092

Helpful numbers (cont'd)

Availity Essentials customer service/technical support
800-282-4548

Ethics and compliance concerns
877-5 THE KEY (877-584-3539)

Fraud, waste and abuse reporting
800-614-4126

Beacon
855-481-7044