Humana Orientation Training

Information for dual Medicare-Medicaid healthcare providers and administrators

Illinois – Effective January 2020
No notable changes for 2020
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1. 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
2. Illinois Medicare-Medicaid Alignment Initiative (MMAI)
General information

• Aid to aged blind disabled (AABD) members:
  - The Medicare-Medicaid Plan (MMP) plan includes benefits for AABD members 21 and older.

• Medicare-Medicaid-eligible deductible/coinsurance:
  - Providers cannot collect coinsurance, copayments, deductibles, financial penalties or any other amount in full or part, for any service provided under this contract.

• Patient enrollment/disenrollment:
  - MMAI eligible individuals can enroll at any time by contacting the Illinois Client Enrollment Services team at:
    • 1-877-912-8880
    • TTY: 1-866-565-8576

• 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.
Behavioral health clinical management program (Beacon)

- Humana has contracted with Beacon Health Strategies to delegate behavioral health functions including, but not limited to:
  - Provider network contracting and credentialing
  - Quality management
  - 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/provider/dashboard or via the following options:
  - **Email:** southeastservicecenterpr@beaconhealthoptions.com
  - **Interactive Voice Recognition (IVR):** 1-855-481-7044
    * Check member eligibility, claims status and authorization status
    * Plan to provide your practice or organization TaxID, the member’s ID number, member’s date of birth and the date of service.
  - **Claims hotline:** 1-855-481-7044
  - **Provider relations:** 1-855-481-7044
  - **Clinical staff:** 1-855-481-7044
  - **EDI/electronic claims:** 1-855-481-7044
    * For an EDI companion guide, please contact edi.operations@beaconhealthoptions.com.
  - **Beacon eServices:** 1-855-481-7044
3. Medicare-Medicaid plans
Purpose of Medicare-Medicaid plans

• You may have heard these plans referred to by different names, such as Medicare-Medicaid Plans (MMP), as well as various other names, depending on the state where the program is administered.

• 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 and social needs of Medicaid clients.

• **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
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 (voice mail 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.
  - Nonemergent transportation service is provided by MTM Inc.
4. Long-term services and support (LTSS)
LTSS

• A member, family member or provider may recommend that the state assess the member for LTSS eligibility.

• Not all plan members are eligible for LTSS.

• LTSS is granted by the state, relative to CMS regulations.

• If the state approves LTSS for the member, Humana will send a case manager to the member’s home to validate functional needs. The case manager will create a care plan and subsequent service plan.
5. Credentialing and contracting
Credentialing

• Healthcare providers must be credentialed to treat Humana members. Please reference the Humana Provider Manual for further details.

• Provider office site evaluations must be completed for all PCP and OB-GYN provider locations prior to participation with Humana.

• Recredentialing occurs at least every three years.

• Some circumstances require shorter recredentialing cycles.

• Humana participates with the Council for Affordable Quality Healthcare (CAQH®).
Requesting a CAQH ID

• Send an email to dadwell@humana.com

• Required information:
  - Provider's full name
  - Date of birth
  - National Provider Identifier (NPI)
  - Specialty
  - Office address
  - Office phone number
Contracting process – required information

- Physician/practice/facility name
- Service address with phone, fax and email information
- Mailing address, if different than service address
- Taxpayer identification number (TIN)
- Specialty
- Medicaid provider number
- National Provider Identifier (NPI)
- CAQH number
- Lines of business (e.g., Medicare Advantage) of interest
- Type of contract (e.g., individual, group, facility)
Contacts for contracting/credentialing

• Medical provider contracting requests:
  - Visit Humana.com/providers
  - Choose “Join Our Network.”
  - Choose “Contracting with Humana.”
  - Complete online form.

• Credentialing status:
  - To check the status of your credentialing or contract, please call Humana Provider Relations at 1-800-626-2741, Monday through Friday, 8 a.m. to 5 p.m. Central time.
Contacts for contracting/credentialing (cont’d)

• Long-term services and support providers (Independent Living Systems-ILS) contracting requests:
  - Illinois providers can call 1-855-661-2029, 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 Strategies provider relations for network contracting and credentialing.
  - Illinois providers can call 1-855-481-7044.
6. Web Resources
Provider website – public

Humana.com/providers

- Health and wellness programs
- Clinical practice guidelines
- Provider publications (including Humana’s Provider Manual – state-specific appendix at humana.com/provider/support/Medicaid-materials/Illinois)
- Pharmacy services
- Claim resources
- Quality resources
- What’s New
- Webinars – Visit Humana.com/providerwebinars to register
Working with Humana online? Use the multipayer Availity Portal

How to register
• Go to Availity

Join us for a training session
• Visit Availity.com/Humana to learn about training opportunities and reserve your space.

Questions?
• Availity help with registration and tools: Call 1-800-AVAILITY (1-800-282-4548)

The Availity Portal 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
✓ Manage claim status
✓ Use Humana-specific tools

About Availity
• Cofounded by Humana
• Humana’s clearinghouse for electronic transactions (EDI) with providers
7. Preauthorization and notification
Preauthorization and notification

• Allows Humana to provide members’ benefit information
• 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 1-800-523-0023 (available 24 hours a day) for automated requests.
• Representatives available 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding major holidays).
• Press “0” or say “representative” for live help.
• Have Tax ID number available.
• To view the preauthorization list, visit Humana.com/PAL and choose the current “Medicare Advantage and Medicare-Medicaid Plans Preauthorization and Notification List.”
Drug prior authorization and notification

• Get forms at Humana.com/pa or call 1-800-555-2546 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time).

• For drugs delivered/administered in physician’s office, clinic, outpatient or home setting:
  - Humana.com/medpa
  - 1-866-461-7273, Monday through Friday, 8 a.m. to 6 p.m. Eastern time
8. 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 claims**
  Smart Data Solutions
  P.O. Box 21596
  Lexington, KY 40512-4605

  **Encounters**
  Humana Claims Office
  P.O. Box 14605 Eagan,
  MN 55121
Timely filing

• 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 HEDIS® reporting. It can ultimately affect how a plan and its providers are measured in member preventive care and screening compliance.

• Fee-for-service claims should be filed as soon as possible, but 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, you will need to use one of the following payer IDs:
  - 61101 for fee-for-service claims (noncapitated)
  - 61102 for commercial encounter claims (capitated)
  - 61105 for delegated encounter claims (Illinois only)
  - 45048 for LTSS claims (ILS)
  - 43324 for behavioral health claims (Beacon)
Electronic claim submission

• Claims clearinghouses:*
  – Availity www.Availity.com 1-800-282-4548
  – Change Healthcare www.changehealth.com 1-888-363-3361
    (formerly Emdeon):
  – TriZetto www.trizettoprovder.com 1-800-969-3666
  – SSI Group www.thessigroup.com 1-800-881-2739

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

• For more information, visit Humana.com/providers, choose “Claims resources,” then “Electronic claims and encounters”

• ILS-preferred clearinghouse: www.changehealth.com
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 detail
  - 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 into the secure provider portal at Availity.com.**
Claim escalation steps

- **Step 1:** Call the number on the back of the member’s ID card.
  - Have reference number handy.
  - Ask for front-line leader.

- **Step 2:** Submit claim dispute to the following address: Humana Provider Correspondence, P.O. Box 14601, Lexington, KY 40512-4601

- **Step 3:** If there is a factual disagreement with the response, send an email with the reference number to humanaproviderservice@humana.com.
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 that found in our database
  - Missing or incorrect information submitted
  - An invalid Healthcare Common Procedure Coding System (HCPCS) code was submitted
  - No authorization or referral found

• **How to avoid these errors:**
  - Ensure that patient information received and submitted is accurate
  - Ensure that all required claim form fields are complete and accurate
  - Obtain proper authorizations and/or referrals for services rendered
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 the risk of lost or stolen checks
- 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 in 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 of a denial of payment for services rendered to members determined not to be medically necessary by Humana, the provider shall not bill, charge, seek payment or have any recourse against the member for such services.
9. 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.
MTM Inc.

• MTM Inc. provides nonemergency transportation for:
  - Medical appointments
  - Visits to nursing homes
  - Pharmacy trips, immediately after physician visits
  - Appointments at other medical providers and locations
  - Ongoing care, such as dialysis

• Depending on the member’s medical condition and location, transportation provided may be by taxi, bus, van, subway, wheelchair vehicle, stretcher van or medical transport.

• Service is curb to curb. Transportation drivers are not allowed to enter homes or medical facilities.
MTM, Inc. (cont’d)

• One escort is allowed, if medically necessary, on a space-available basis. Escorts must be 18 or older.

• When possible, transportation should be scheduled at least three days in advance by calling 1-855-253-6867.

• When trips cannot be scheduled in advance, such as trips to return home following medical appointments when a departure time is unknown, members may still call MTM Inc. at 1-855-253-6867.

• TTY users can dial 711 to access the local provider.
MTM, Inc. (cont’d)

- Hours of operation for phone lines are Monday through Friday, 8 a.m. to 8 p.m. Central time.
- Members also can schedule via the MTM Inc. member portal 24/7 – http://memberportal.net/.
- Providers can help members schedule trips via the MTM, Inc. facility portal – https://smp.mtm-inc.net/.
10. Helpful numbers
Helpful numbers

- **Medicare and Medicaid customerservice:**
  - Please call the number on the back of the member’s ID card for the most efficient call routing.

- **Prior authorization (PA) assistance for medical procedures:**
  - 1-800-523-0023, Monday through Friday, 8 a.m. to 8 p.m. Eastern time

- **PA for medication billed as medical claim:**
  - 1-866-461-7273, Monday through Friday, 8 a.m. to 6 p.m. Eastern time

- **PA for pharmacy drugs:**
  - 1-800-555-2546, Monday through Friday, 8 a.m. to 6 p.m. local time
Helpful numbers (cont’d)

• Provider relations (answering as health planning and support)
  - 1-800-626-2741, Monday through Friday, 8 a.m. to 5 p.m. Central time (fee-schedule requests, demographic changes and credentialing status)

• Medicare/Medicaid case management: 1-800-322-2758

• Medicare/Medicaid concurrent review: 1-800-322-2758

• Clinical management program information: 1-800-491-4164

• Humana Pharmacy: 1-800-379-0092
Helpful numbers (cont’d)

• Availity customer service/technical support: 1-800-282-4548

• Ethics and compliance concerns: 1-877-5 THE KEY (1-877-584-3539)

• Fraud, waste and abuse reporting: 1-800-614-4126

• Independent Living Systems (ILS): 1-855-661-2029

• Beacon: 1-855-481-7044