Claims Education Overview

Humana Healthy Horizons

Indiana PathWays for Aging

2025 IHCP Works Annual Seminar

Humana®

Agenda

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Who We Are

The Claims Research and Resolution team performs root-cause analysis on all Humana Indiana PathWays for Aging claim inquiries. This team will review your inquiry and coordinate with internal departments and your Provider Relations Representative to resolve the issue in a timely manner.

Team Overview

Humana Claims Research & Resolution Team

Heather Baecher: Manager, Claims Research & Resolution

Krista Elmore: Senior, Claims Research & Resolution Professional

Jordan Adams: Claims Research & Resolution Professional

Janet Stone: Claims Research & Resolution Professional

Kristen Davidson: Claims Research & Resolution Professional

Ryan Kirchgessner: Claims Research & Resolution Professional

Logan Humphrey: Claims Research & Resolution Professional

If you have any claims or billing questions, please reach out to us any time at INMedicaidClaimsResearch@humana.com

Additional Resources: Indiana Medicaid: Provider - Claims and Payments

Humana Healthy Horizons in Indiana PathWays for Aging Long-Term Services and Supports/Home and Community-Based Services Provider Representatives Map

Region 1

INLTSSProviderRelations_T1@humana.com
Katelynn Koedyker - (219) 296-8295

Region 2

INLTSSProviderRelations_T2@humana.com
Katelynn Koedyker - (219) 296-8295

Region 3

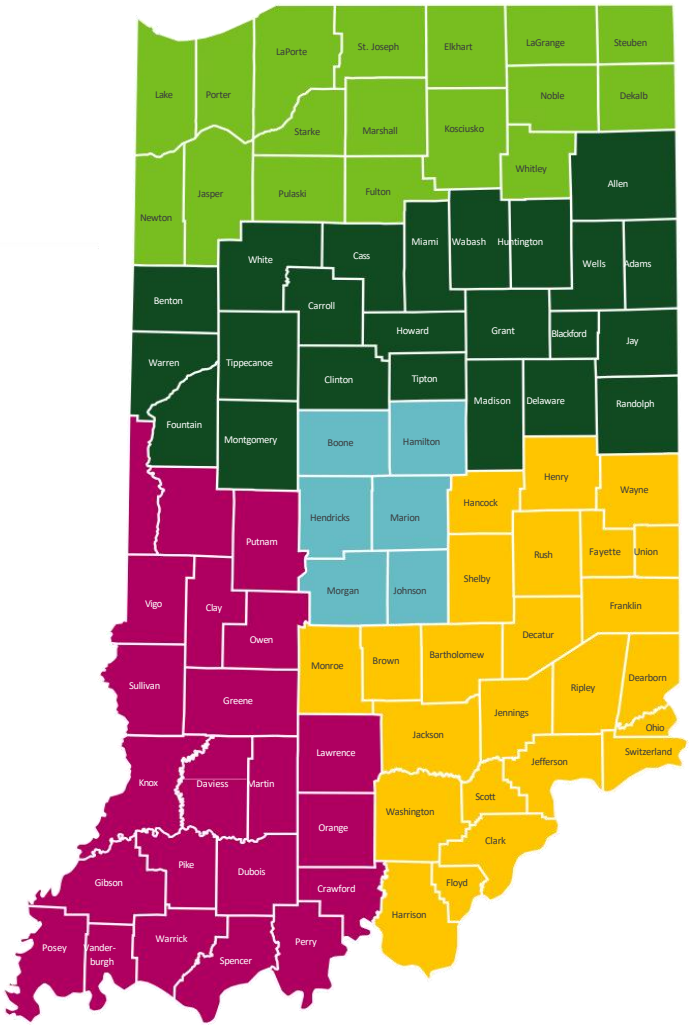
INLTSSProviderRelations_T3@humana.com
Celina Alicea (765) 415-9344

Region 4

INLTSSProviderRelations_T4@humana.com
HCBS Provider Representatives

Region 5

INLTSSProviderRelations_T5@humana.com
HCBS Provider Representatives



Assisted Living

INLTSSNursingFacilityAssistedLiving@humana.com
Jessie Iden - (574) 275-3573

Adult Day Services

INLTSSAdultDayHospice@humana.com
Kimberly Dunn - (812) 914-3104

Attendant Care/Home and Community Assistance

INLTSSPersonalCareAttendant@humana.com
Cierra Rich - (260) 298-4348
Bria Steele - (317) 677- 2693

Humana Healthy Horizons in Indiana PathWays for Aging Behavioral Health, Physical Health, and Nursing Facility Provider Representatives Map

Region 1

INMedicaidProviderRelations_T1@humana.com
Brittani Fox - (219) 216-5588

Region 2

INMedicaidProviderRelations_T2@humana.com
Jelaina Hollingsworth - (346) 236-4261

Region 3

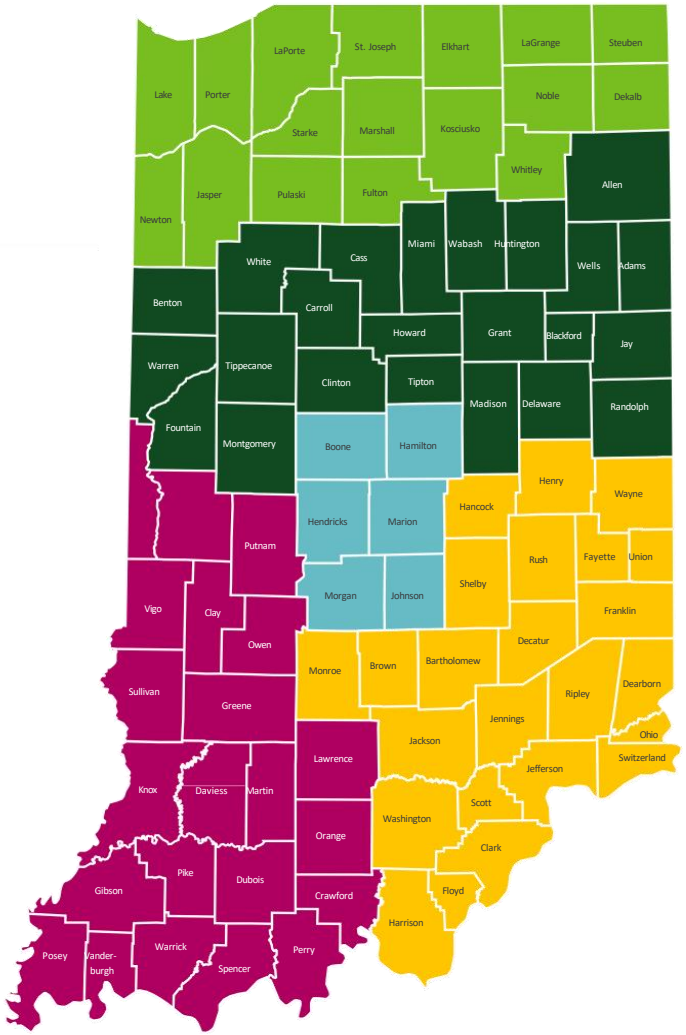
INMedicaidProviderRelations_T3@humana.com
Jelaina Hollingsworth - (346) 236-4261
Lauren Savitskas - (317) 793-8028

Region 4

INMedicaidProviderRelations_T4@humana.com
Mychelle Christian - (812) 204-9285

Region 5

INMedicaidProviderRelations_T5@humana.com
Lauren Savitskas - (317) 793-8028



Skilled Nursing Facilities

INLTSSNursingFacilityAssistedLiving@humana.com
Jessie Iden - (574) 275-3573

Hospice

INLTSSAdultDayHospice@humana.com
Kimberly Dunn - (812) 914-3104

Claims Overview

Claim Inquiry Examples

Fee schedule errors

Participating/ nonparticipating provider issues

Coordination of benefits (COB) updates

Availity Essentials rejections

Claim denials

Wrap/encounter inquiries

Medicaid ID Inquiries

Taxonomy/National Provider Identifier (NPI) inquiries

Humana Claims Recoupments/Overpayments

The Claims Research and Resolution team does not manage claims related to overpayments or those already designated for recoupment. For assistance with these issues, please contact our Provider Payment Integrity Department or you may also manage most of your requests through Availity.
To report an overpayment, please visit Availity.com/Essentials and select “Claims & Payments.”

If you do not see this option, please ask your organization’s Availity Essentials administrator for access to “Claim Status.” Alternatively, you may call our Provider Payment Integrity Department at 800-438-7885, Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, for a first-level review. You will receive confirmation of your request within 7 business days, and the review process may take up to 45 business days.
If you already have a reference number from Provider Payment Integrity, you may email **HelpPPI@Humana.com** for a second-level review. Please note, initial requests should not be sent to this email address.

Humana Recoupments

Reasons for a recoupment; including but not limited to:

- Paid too much on a claim
- Paid for services not IHCP certified to render
- Paid for services provider isn't contracted to render
- Paid for more services than authorized
- Member was ineligible at the time of service
- Services rendered at a location not authorized (i.e., attendant care at a nursing facility or assisted living)

Recoupment Letter

- Letter is sent roughly sixty (60) days prior to recoupment process is initiated
- Guesstimate Date is listed on the letter

Who to contact?

- HelpPPI@humana.com

Recoupment Letter

Humana
Attn: Provider Payment Integrity
P.O. Box 14601
Lexington, KY 40512-4601

April 17, 2025

[redacted]

Refund request—see enclosed chart

Dear [redacted]

Humana strives to offer its members high-quality healthcare at affordable rates. To facilitate this objective, we review our payments for accuracy. While it is certainly our desire to pay all claims accurately the first time, we occasionally find that claims have been paid incorrectly. As part of a recent review, we determined the claims referenced on the enclosed chart were overpaid by [redacted]. The reasons for the overpayments are listed on the chart. Please review your files with the enclosed chart. Please review your files with the enclosed chart.
If you agree with our findings, please send a refund, along with a copy of the chart, on or before the anticipated remit deduct date listed within the chart for each claim to:

Humana
P.O. Box 931655
Atlanta, GA 31193-1655

If we do not hear from you, this will signal to us that you agree with our findings, and Humana will start deducting the overpayments from your future payments.

If you do not agree with these findings, wish to dispute this notice or have questions regarding an overpayment, you can manage Humana overpayments electronically with the Availity Essentials™ online overpayment application at www.availity.com/essentials. To access the overpayments application, log in to Availity Essentials and select Claims & Payments | Overpayments. To learn more about getting started with Availity Essentials, please visit **www.availity.com/essentials.**

If you prefer, you can call us at **800-438-7885 (TTY: 711)**. Representatives are available Monday – Friday, 8 a.m. – 8 p.m., Eastern time. If you call us, please provide the following information:

- Healthcare provider's name, Tax Identification Number, phone and fax numbers
- Patient's name, Medicaid ID and date of birth
- Claim number and date of service for the claim
- Brief description of request

If you have already issued a refund check for these claims, please disregard this request and accept our thanks. If not, it is important that we hear from you to resolve this refund request and avoid having the overpaid amount deducted from future payments or referred to our outside collection agency.

395506MUL0224-A GCHM6C2EN FR1000
P025041700005992

Sincerely,

The Humana Provider Payment Integrity Department

Enclosure: Overpayment chart

Medicare regulations 42 C.F.R. §424.44(b) allow for exceptions to the one calendar year time limit for filing Medicare claims. Retroactive Medicare entitlement involving the state Medicaid agencies, where a state Medicaid agency recoups payment from a provider or supplier six months or more after the date the service was furnished to a dually eligible beneficiary, is an allowed exemption. Refer to Chapter 1, subsection 70.7 of the Medicare Claims Processing Manual for qualifying exceptions and associated billing instructions.

PPI Overpayment Chart: Provider Review

Created 04/17/2025
L1 Action From 04/16/2025
Humana internal provider ID number: [redacted]
Provider tax ID: 4
Control Number [redacted]

[redacted]	SUF	REL	Claim number	Date of service	Overpaid amount	Recovery item number	Reason	Source	LOB	MKT	PLT CD
Patient: [redacted]											

Medicaid ID Number: [redacted]
Member Date Of Birth [redacted]
Patient Acct. Number: [redacted]
Payment Type: ELECTRONIC
Check Date: 08/28/2024
Check Number: [redacted]
Original Paid Amount: $133.44
Legal Entity:
Anticipated Remit Deduct Date: 06/15/2025
Note: [redacted]

Humana Claims Overview

Humana Healthy Horizons follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. It is critical to ensure all required procedure codes, modifiers, International Classification of Disease, 10th Revision (ICD-10) diagnosis codes, and place of service codes are included on the claim to ensure timely processing and payment delivery. Failure to provide required information on submitted claims will result in denial.

What is a clean claim: Claims submitted correctly the first time are considered a clean claim. This means that all fields and applicable supporting documents necessary to adjudicate the claim is/are provided with the first submission.

Submitting your routine claims electronically has the following benefits:

- Faster claims processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claim status
- Minimal staff training and cost
- Electronic Claims can be submitted by using Availity Essentials

Humana Claims Processing Timeframes

Electronic clean claims are paid/denied within the following time frames:

- Home-and Community-Based Services (HCBS) claims are processed within 7 business days of receipt.
- Non-HCBS claims are processed within 21 calendar days of receipt.

Paper Claims are paid/denied within the following time frames:

- Pay or deny both the HCBS-related and non-HCBS related claim within 30 calendar days after receipt of a clean claim.
- Paper claims are scanned for clean and clear data recording, so it is important to ensure paper claims are legible and submitted in the proper format.

Humana Crossover Claims

Crossover Claims are recipients who have both Traditional Medicare and Medicaid coverage.

- Providers should file claims in the appropriate manner with Wisconsin Physicians Service (WPS), making sure the recipient's Medicaid number is included on the Medicare claim form. Once Medicare has processed/paid its percentage of the approved charges, Medicare will electronically submit a 'crossover' claim to the Medicaid fiscal intermediary that includes the coinsurance and/or deductible.
- For Medicare Advantage coverage, providers should file the claims to Medicaid once the Medicare Advantage explanation or reimbursement or explanation of benefits is received. Please be sure to include the Explanation of Remittance/Explanation of Benefits for processing.
- Providers are not required to submit a claim to Medicaid for the aligned Dual Special Needs Plan members. Humana will automatically process the claim for reimbursement once the claim has processed/paid its percentage of the approved charges on the Humana Medicare side.

Humana Claims Procedure and Diagnosis Codes

Procedure and diagnosis codes

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifies that the healthcare industry use the following four code sets when submitting healthcare claims electronically:
- ICD-10-CM, available from the U.S. Government Publishing Office by calling **202-512-1800** or faxing **202-512-2250**, and from other vendors
- Current Procedural Terminology (CPT) available at AMA-assn.org/practice-management/cpt.
- Healthcare Common Procedure Coding System (HCPCS), available at **CMS.gov/medicare**.
- National Drug Codes, available at **FDA.gov**.

Humana Claims CPT/HCPC Codes

HIPAA-compliant, CPT, HCPCS, and modifiers when modifiers are applicable
Please note: Humana Healthy Horizons also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reducing administrative burdens on providers and health plan organizations. Local or proprietary codes are no longer allowed.

Unlisted CPT/HCPCS codes
If a procedure is performed that cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:

- A full, detailed description of the service provided
- A report, such as an operative report or a plan of treatment
- Other information that would assist in determining the service rendered

As an example, the code 84999 is an unlisted lab code that requires additional explanation.

Claims Submission

Humana Claims Submission

New Claims must be submitted within:

- **90 calendar days from** the date of service for in-network and out of network providers.

Corrected Claims must be submitted:

- **90 calendar days from** the date of service or from discharge for in-network providers.
- Corrected claims that originally paid or partially paid must be submitted within 60 calendar days from the date of the final outcome.
- A corrected claim requires the use of frequency code '7' for a Professional claim and type of bill 'XX7' for an Institutional claim. Be sure to reference the original claim number for accurate adjudication.

Electronic Claims can be submitted by using Availity Essentials

- You can track the progress of submitted claims through the Availity Essentials portal
- Payor ID 61101
- An encounter claim is one that gets processed, but the provider will not receive payment. A common reason this happens, is the selection of 'professional and/or facility encounter' within Availity which both utilize Payor ID 61102.

Paper Claims can be mailed to:

Humana Claims
P.O. Box 14169
Lexington, KY 40512-4169

Corrected Claim for Provider Billing – Professional and Institutional Claim Forms

Definition:
A corrected claim is a resubmission of a previously submitted healthcare claim by a provider, with corrections or updates made to the original information. This is typically done to fix errors, omissions, or inaccuracies that caused the initial claim to be denied, delayed, or paid incorrectly.

Key Points:

- Submitted when the provider identifies mistakes on the original claim (e.g., incorrect patient information, coding errors, missing documentation, or billing discrepancies).
- Must clearly indicate that it is a "corrected claim," often by marking the claim form or selecting the appropriate option in electronic billing systems.
- Requires referencing the original claim number to ensure proper linkage and processing by the payer.
- Helps ensure accurate and timely reimbursement for services rendered.
- Supports compliance with payer policies and regulatory requirements regarding claim submissions and corrections.
- Commonly used in both paper and electronic claim processes across commercial insurers, Medicare, and Medicaid.

Corrected Claim for Provider Billing – References

Purpose:
To facilitate the accurate processing and payment of healthcare claims by correcting errors that could otherwise result in claim denials, underpayments, or overpayments.

Reference:
Centers for Medicare & Medicaid Services (CMS) – Medicare Claims Processing Manual, Chapter 1: General Billing Requirements, Section 130 – Corrected and Replacement Claims.
CMS Manual System - Pub. 100-04 Medicare Claims Processing

Claim Submission and Processing Medicaid Provider Reference Module

Corrected Claim Accuracy and Common Errors

To minimize the need for corrected claims, providers should take care to avoid these common errors:

- Incorrect patient information (such as misspelled names, wrong date of birth, or incorrect insurance policy numbers)
- Inaccurate provider details (such as NPI, use of LPI for atypical/HCBS providers, tax ID, or billing address errors)
- Coding errors (use of incorrect CPT, HCPCS, or ICD-10 codes, or missing/incorrect modifiers)
- Incorrect dates of service (including future dates, transposed numbers, or mismatched service periods)
- Omitted or misreported units of service
- Missing or invalid authorization or referral numbers
- Duplicate billing for the same service or procedure
- Errors in charge amounts or billing for non-covered services
- Incorrect place of service codes
- Failure to submit required documentation or medical records
- Submitting claims under the wrong provider or group
- Not following payer-specific rules for bundling and unbundling procedures

Corrected Claim Accuracy and Common Errors - Reference

By ensuring accuracy and completeness in initial claim submissions and staying up to date with payer requirements, providers can reduce rework and speed up reimbursement.

Reference:

Centers for Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 1, Section 80—General Errors and How to Avoid Them.

CMS Claims Processing Manual

Corrected Claims Common Denials 1

Common denials identified by the Claims Research and Resolution team:

- **N45 -** typically indicates that an HCBS provider is billing for services that are not included in their contract. When providers first register, an assessment form is completed with the contracting department, selecting the specific services to be provided. If certain services were not selected on this form, claims for those services will not be paid until the assessment form is updated. To resolve this, providers should contact **LTSSContracting@Humana.com** to update their assessment and ensure all intended services are included.
- **338** – Multiple months cannot be billed on one claim. This is a denial for billing multiple months on the claim. Providers cannot bill multiple months for members (if there is a waiver or liability).
- **86E**- Claim lines not verified by EVV Vendor Sandata.
  - validate visits are entered into Sandata before submitting to Humana or the claim will automatically deny for no visit found since it wasn't in there at the time of submission.
  - validate the number of units entered in Sandata match what is being submitted on your claim because if you bill more than what is in Sandata it will deny the claim for units not matching.
  - validate you are billing with the right billing profile. For example, if a provider is billing HCBS services with a medical billing profile that uses an NPI, the system will not see the visit in Sandata even though it is in there before the claim was submitted because it is searching for the medical Medicaid id instead of the waiver Medicaid id since that is what was submitted on the claim.
  - HCBS services should be billed with an atypical billing profile which does not have an NPI and Home Health claims should bill with a medical billing profile that does use an NPI.

Corrected Claim Common Denials 2

Common denials identified by the Claims Research and Resolution team:

- **313**- no valid billing Medicaid id on the claim. Commonly, this denial is due to the provider not entering their waiver Medicaid id on file with the state on the claim. We also tend to see where the member's Medicaid id is entered in this field in error, which can also cause a **773** denial. For HCBS providers, you can set up as an atypical provider in Availity, by going to "Manage My Organization" and select "Add Provider." Enter the provider details, including the correct tax ID, then check the atypical provider box to remove the NPI field. Before saving, click "Add Identifier (+)" and enter the Medicaid ID used for waiver services, so it is included on all claim submissions. Once this is complete, selecting the atypical profile in the provider dropdown will automatically populate the Medicaid ID field and omit the NPI field.
- **775**- No match to zip code. A zip code mismatch denial occurs when the ZIP+4 code submitted on your claim does not exactly match what was provided on your W9 during IHCP enrollment. The system uses a crosswalk of your Billing NPI, Billing Taxonomy, and either the Service Facility ZIP+4 (if one is on the claim) or Billing ZIP+4 to verify this information. For successful claim processing, ensure that the ZIP+4 on your claim matches the ZIP+4 on your W9 form precisely. The claim will deny if this information is not an exact match.
- **088**- Duplicate bill previously processed denials often occur when providers submit more than one claim for members with dual coverage, or when a claim is resubmitted before the initial submission has been processed (**066**). This does not speed up payment and can result in denials. If you experience a claim discrepancy with Humana on your initial submission, please contact us for assistance. We will research the issue and advise you on the appropriate next steps.
- **87P -** Appropriate modifier not billed on the claim.

Availity Registration

Humana Healthy Horizons and Availity Essentials

Availity Essentials is Humana Healthy Horizons' electronic data interchange (EDI) clearinghouse and our preferred multipayer portal for healthcare providers.

Humana Healthy Horizons cofounded Availity Essentials and is one of several current payer-owners.

Availity Essentials is the portal solution provided by Availity.

Availity Essentials' advantages:

- One user ID and password, many payers
- Up-to-date and user-friendly interface
- No cost to register or use the tools
- Dedicated customer service line
- Extensive online help and training

How to Register for Availity

Availity Essentials is Humana Healthy Horizons' electronic data interchange (EDI) clearinghouse and our preferred multipayer portal for healthcare providers.

All Providers:

- All providers start the registration process by navigating to www.availity.com and selecting 'Get Started' from the top right corner of the screen.

- Please note, the designated administrator must be the one to register the organization. The designated administrator can be edited in 'Manage My Organization' at any time.

- ***If the provider offers both skilled and non-skilled services the provider will choose the Taxonomy for the waiver provider as primary during registration and then later will create a separate profile for each service type. One for the waiver services and one for the skilled services in 'Manage My Organization'. At this step, the provider will be able to add the NPI for the skilled services.

For a step-by-step guide on getting registered in Availity:
Register your provider organization (availity.com)

How to Register for Availity: HCBS Provider

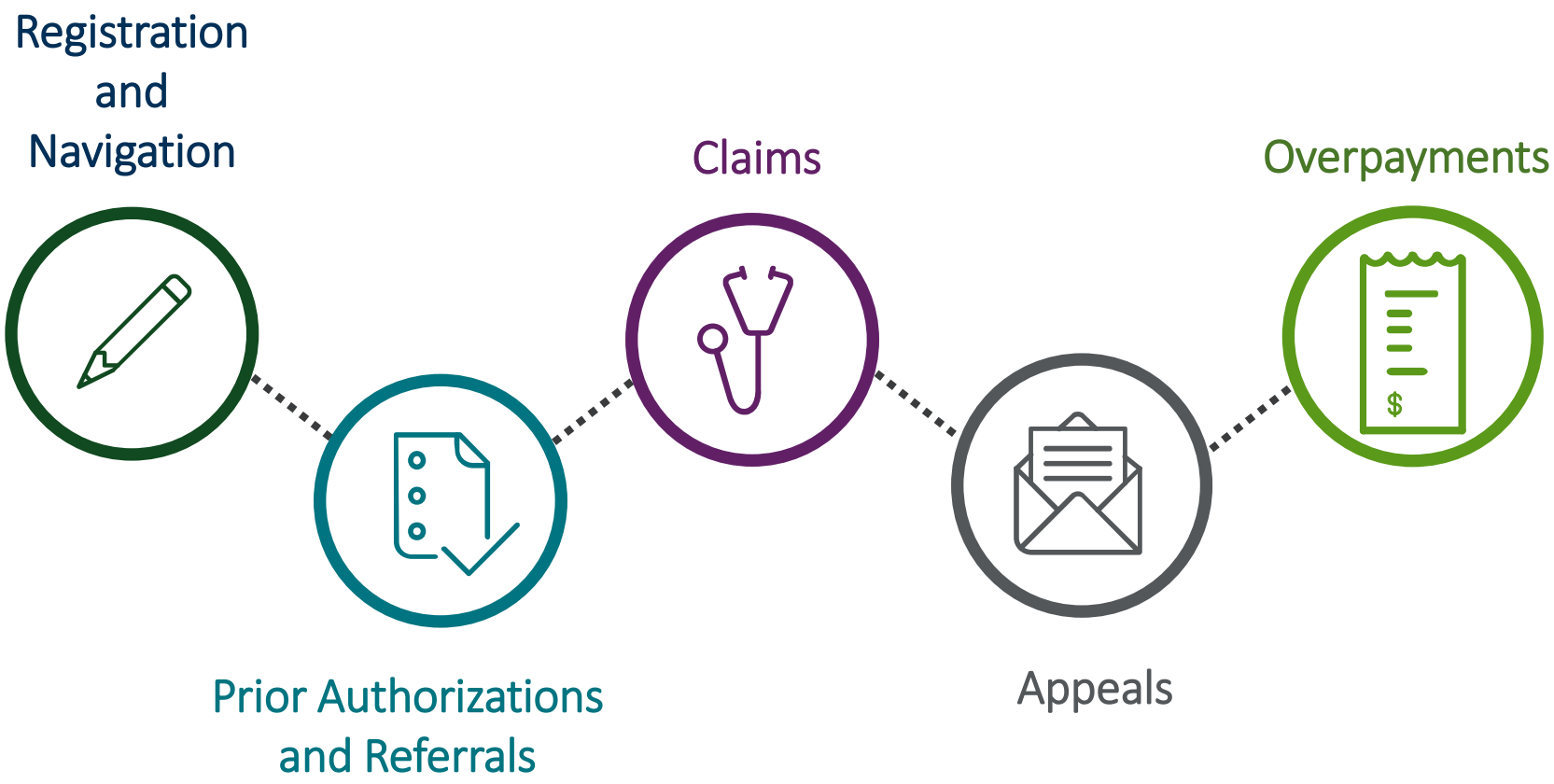
Availity Essentials is Humana Healthy Horizons' electronic data interchange (EDI) clearinghouse and our preferred multi-payer portal for healthcare providers.

Home-and Community-Based Services (HCBS) Providers Specifically:

- HCBS Providers providing non-medical/non-licensed care are considered *Atypical/Non-Medical Providers*
- Atypical providers should select the option "**This organization does NOT have an NPI.** This organization is an atypical provider and does not provide healthcare as defined in 45 Code of Federal Regulations (CFR) section 160.103."
- Because atypical and HCBS providers do not have an NPI, the LPI should be used when submitting clean claims as well.

For a step-by-step guide on getting registered in Availity:
Register your provider organization (availity.com)

Availity Essentials Features for Healthcare Providers



Availity Essentials Registration

Identify your administrator.

Obtain your user ID and password.

Access tools and training.

Availity Registration Guide

Availity Essentials Resources

Availity Essentials has many resources available to you. The table below shows how and where you can access the resources.

Provider Help Center (Availity Essentials documentation)	**Availity Learning Center** (Availity Essentials learning materials)	**Availity Client Services** (Availity Essentials call center)
From your Availity Essentials home page, select the **Help & Training** menu. Select **Find Help**, and the Provider Help Center launches. Select an application-specific tile or type in the search field to see specific information and resources about each application.	From your Availity Essentials home page, select the **Help & Training** menu. Select **Get Trained** and the Availity Learning Center (ALC) launches.	From your Availity Essentials home page, select the **Help & Training** menu. Select **Availity Support** to submit an online ticket, chat with an Availity Client Services (ACS) representative or call ACS at **800-282-4548**, Monday – Friday, 8 a.m. – 8 p.m. Eastern time.

Helpful Availity Contacts and Resources

Help with the Availity Essentials Portal
Availity Client Services
Phone: 800-AVAILITY (800-282-4548)
Monday – Friday, 8 a.m. – 8 p.m., Eastern time, excluding holidays
Online support tickets: **Help & Training → Availity Support → Support Tickets**

Working with Humana Healthy Horizons Online
Humana.com/ProviderSelfService

Humana Provider Services Line
Phone: 866-274-5888, Monday – Friday, 8 a.m. – 8 p.m., Eastern time

Informal/Formal Disputes

Humana Informal Disputes

If you disagree with the outcome of a claim, or if you have not received a determination within 30 calendar days, you may begin the Humana Healthy Horizons in Indiana provider claim payment dispute process. The process consists of two steps, an informal dispute and formal dispute. An informal dispute must be submitted prior to submitting a formal dispute.

Informal Claims Dispute: must be received within 60 calendar days of the notice of Humana's determination. Humana will resolve the informal dispute within 30 calendar days of receipt of the dispute and send a resolution letter. Most issues are resolved at the informal claim dispute step.

Online: Availity

Email: INMedicaidClaimsResearch@humana.com

Mail to:
Humana Healthy Horizons in Indiana Informal Claim Dispute
P.O. Box 14169
Lexington, KY 40512-4601

Humana Formal Disputes

Formal Claim Dispute: if additional review is necessary, you can submit a formal dispute to Humana in writing. The formal dispute can be submitted within 60 calendar days after the 30-day informal dispute time frame. Please include documentation from the informal dispute as well as any new or additional documents. Humana will provide a determination within 45 calendar days and send a resolution letter.

Email:
IndianaFormalDispute@humana.com

Mail to:
Humana Healthy Horizons in Indiana
Attn: Formal Disputes
201 North Illinois Street Suite 1200
Indianapolis, IN 46204

Please be sure to include member name and ID number, date of service, claim number, name of the servicing provider, charge amount, payment amount, difference between the amount paid and the alleged correct payment amount, and a brief explanation of the basis for the contestation.

Additional Resources

Indiana Medicaid: Provider - Claims and Payments (humana.com)

- Out-of-network Claims
- Overpayment Information
- Quick Reference Guide for Claim Processing

2024 Provider Policy and Procedures Manual

- Chapter 12: Claims and Billing
  - EFT Process
  - EDI Clearinghouses
  - Procedure and Diagnosis Code Sets

INMedicaidClaimsResearch@humana.com

- Assistance with any claims or billing questions

Humana Healthy Horizons

PathWays FOR AGING

Please take a few minutes to complete the event and session evaluations!

Humana®