2026 Humana Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) Provider Orientation and Annual Compliance Training

Information for dual Medicare-Medicaid healthcare providers and administrators serving Humana FIDE-SNPs members

Humana®

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Topics covered

Training topics are based on:

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

Welcome to Humana's FIDE-SNP in Illinois

Welcome to Humana’s FIDE-SNP in Illinois

Welcome and thank you for becoming a participating provider with Humana’s FIDE-SNP in Illinois.

IDHFS is transitioning its Medicare-Medicaid Alignment Initiative demonstration program to a FIDE-SNP effective Jan. 1, 2026.

What is a FIDE-SNP?
A FIDE-SNP is a type of health plan that covers both Medicaid and Medicare benefits. For enrollees enrolled in Humana’s FIDE-SNP, healthcare providers **cannot** collect coinsurance, copayments, deductibles, financial penalties or any other amount, in full or part, for any covered service provided, except as otherwise specified.

Who is eligible?
To be eligible for enrollment with Humana, individuals must meet all the following requirements:

1. Receive full Illinois Medicaid benefits
2. Be 21 or older at the time of enrollment
3. Eligible for enrollment or be enrolled in Medicare Part A, enrolled in Part B, and eligible to enroll in a Part D plan (full-benefit dually eligible beneficiaries as of the effective date of coverage under the FIDE-SNP).

You can find more information on **Illinois' website**.

Key objectives of FIDE-SNP

Key objectives of the FIDE-SNP are:

- To advance health equity
- To improve the quality of healthcare outcomes
- To limit disruptions in healthcare access
- To reduce healthcare costs
- To promote fully integrated, whole-person care

Provider resources and supports

Provider manuals and provider website

You can find additional information on all topics covered within this orientation in the Humana Illinois FIDE-SNP Provider Manual. We update our provider manual at least annually. It serves as an extension of your provider agreement. You can find our provider manual on **Humana's provider website**.

Additional resources available on our **provider website** include the following:

- Clinical practice guidelines
- Pharmacy services
- Claim resources
- Quality resources
- What's new

For information related to pharmacy benefits, please refer to our Pharmacy Provider Manual **located on our pharmacy resources website**.

Availity Essentials

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

- Use 1 site to work with Humana and other payers.
- Check eligibility and benefits.
- Submit referrals and authorization requests.
- Submit claims and check claim status.
- Use Humana-specific tools.

About Availity Essentials

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

Providers can register for Availity Essentials

Availity Essentials offers free product training for registered users. Sign in to Availity Essentials and select Help & Training to get started.

Questions?

- Availity Essentials helps with registration and tools:
  Call 800-AVAILITY (282-4548),
  Monday – Friday, 8 a.m. – 8 p.m.
  Eastern time.

State resources

Additional resources and information are available at the following Illinois websites:

- **Illinois Department of Healthcare and Family Services**
- **HealthChoice Illinois website**
- **Illinois Department on Aging**
- **Illinois Department of Human Services**
- **Illinois Department of Human Services Division of Rehabilitation Services**
- **Illinois Application for Benefits Eligibility**

Contact Information

Contact description	Contact information	Hours of operation (all times Central)
Humana Provider Services	800-787-3311	Monday – Friday, 7 a.m. – 7 p.m.
Provider Relations Fee schedule requests, demographic changes and credentialing status	800-626-2741	Monday – Friday, 8 a.m. – 5 p.m.
Humana Clinical Pharmacy Review Prior authorization for pharmacy drugs	Phone: 800-555-CLIN (2546) Fax: 877-486-2621	Monday – Friday, 7 a.m. – 10 p.m.
Medication Intake Team	866-461-7273	Monday – Friday, 7 a.m. – 5 p.m.
CenterWell Pharmacy®	800-379-0092	Monday – Friday, 7 a.m. – 10 p.m. and Saturday, 7 a.m. – 5:30 p.m.
Availity Essentials Customer service/technical support	800-282-4548	Monday – Friday, 7 a.m. – 7 p.m.

Contact information (cont'd.)

Contact description	Contact information	Hours of operation (all times Central)
Ethics and compliance Concerns related to ethics or compliance	877-5-THE-KEY (877-584-3539)	24/7 access
Fraud, waste and abuse Reporting fraud, waste or abuse	800-614-4126	24/7 access
Carelon℠ Behavioral Health (BH) For all BH inquiries	800-397-1630	Monday – Friday, 7 a.m. – 7 p.m.
Illinois Department of Healthcare and Family Services (IDHFS) Client Enrollment Services Call Center	877-912-8880 (TTY: 866-565-8576)	Monday – Friday, 8 a.m. – 6 p.m.

For a full list of all contact information, please review the **Humana Illinois FIDE-SNP Provider Manual**.

Credentialing and contracting

Credentialing

Humana credentials providers in accordance with the National Committee for Quality Assurance (NCQA®) credentialing standards as well as applicable IDHFS, Department of Human Services (DHS), Illinois Department of Aging (IDoA), Illinois Department of Insurance, and federal requirements. In addition to being in good standing with Medicare and federal, state and local agencies, you must be free from active IDHFS sanctions.

You must be credentialed prior to participating in the Humana FIDE-SNP network and treating enrollees. You can complete credentialing by completing the following steps:

1. Enroll in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system.

2. Register with the Council for Affordable Quality Healthcare (CAQH) at **the CAQH Provider Data Portal**. Once you submit the registration, 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.

All Illinois FIDE-SNP network providers must be recredentialed every 3 years. At recredentialing and on a continuing basis, Humana verifies minimum credentialing requirements.

To check credentialling status, please call Humana Provider Relations at 800-626-2741, Monday – Friday, 8 a.m. – 5 p.m., Central time.

For more information about credentialing, please review the **Humana Illinois FIDE-SNP Provider Manual** and **the state's IMPACT website**.

Contracting and joining the network

To join our network, follow the instructions outlined below based on your provider type:

All providers:

1. Visit **Humana's provider webpage**
2. Choose “Join Our Network”
3. Choose “Contracting with Humana”
4. Complete online form

Long-term services and supports (LTSS) providers may also call 800-626-2741, Monday – Friday, 8 a.m. – 5 p.m., Central time.

BH providers contracted by Carelon℠ should visit **Carelon Behavioral Health's provider website**.

You may be asked to provide the following details when requesting to join our network:

- Provider, 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)

To check contract status for medical or LTSS providers, please call Humana Provider Relations at 800-626-2741, Monday – Friday, 8 a.m. – 5 p.m., Central time.

Member enrollment and eligibility

Member enrollment and disenrollment

Determination of eligibility

IDHFS determines a member's eligibility and provides eligibility information to Humana.

Eligibility criteria

To be eligible for Illinois FIDE-SNP, individuals must receive full Illinois Medicaid benefits; are 21 and older at the time of enrollment; are entitled to or enrolled in Medicare Part A, enrolled in Part B, and eligible to enroll in a Part D plan (full-benefit dually eligible beneficiaries as of the effective date of coverage under the FIDE-SNP).

Open enrollment

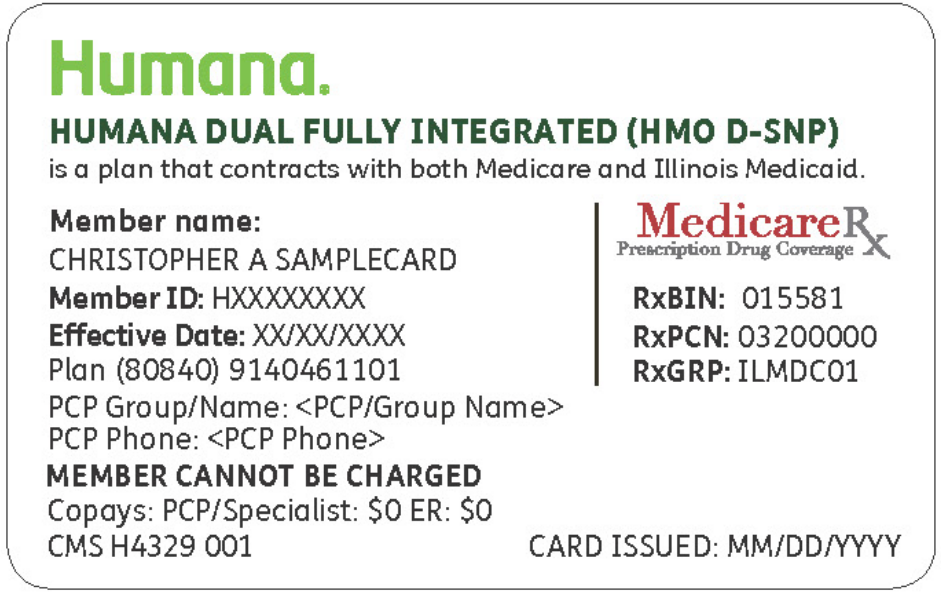
Open enrollment refers to the specific period each year in which an enrollee has the opportunity to change from one managed care organization (MCO) to another. Members who do not select an MCO during this period remain with their current MCO. Members have 90 calendar days after open enrollment to change MCOs.

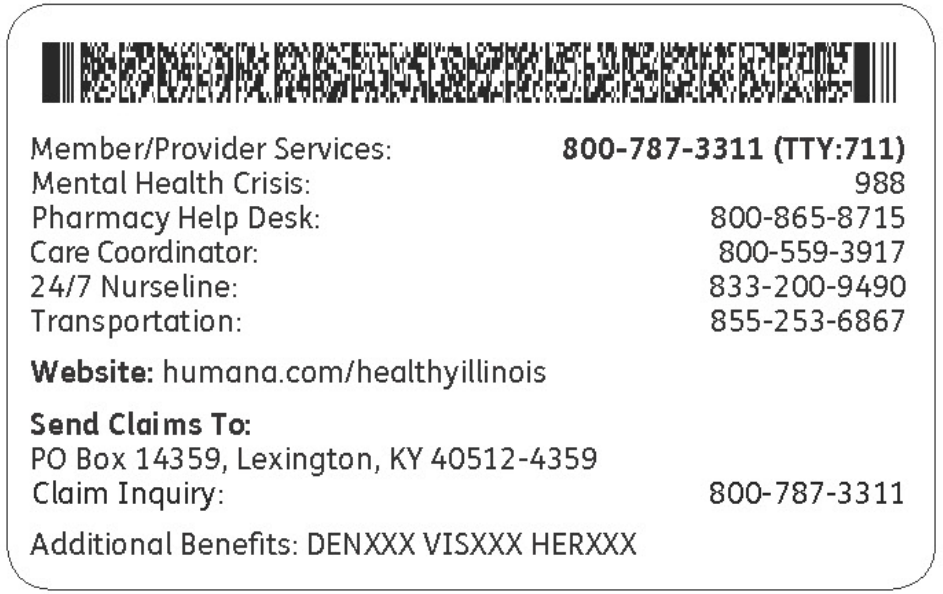
Enrollment and disenrollment process

FIDE-SNP-eligible individuals can enroll and disenroll anytime by calling the Illinois Client Enrollment Services team at 877-912-8880 (TTY: 866-565-8576), Monday – Friday, 8 a.m. – 6 p.m., Central time.

Member ID card

All new Humana members receive an enrollee ID card. A new card is issued only if the information on the card changes, the card is lost, or an additional card is requested. Please ask Humana members to present their ID card at the time of service. Photos of sample enrollee ID cards appear below. Please note: These sample IDs comply with state guidelines and are subject to change without notice.





Verifying member enrollment and eligibility

Since member eligibility changes occur frequently, you should verify member's eligibility on admission to, or initiation of, treatment and on each subsequent day or date of service to facilitate reimbursement for services. The member ID card is used to identify a Humana member but does not guarantee eligibility or benefits coverage because enrollees may disenroll from Humana or lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to rendering any service.

How to verify member eligibility for covered BH services?

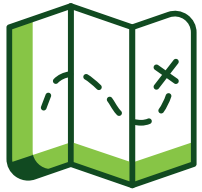
To verify eligibility for member receiving BH services, providers can check Availity Essentials or call Carelon Provider Service at 855-481-7044, Monday – Friday, 7 a.m. – 5 p.m., Central time.

How to verify member eligibility for non-BH covered services?

Eligibility for non-BH services can be verified by signing in to **Availity Essentials**, navigating to Patient Registration, then selecting Eligibility and Benefits Inquiry.

Primary care provider assignment and reassignment

Members choose or are assigned a primary care provider (PCP) on enrollment with Humana. Members can select a PCP from Humana's provider directory or by calling the phone number on their member ID card. If a member does not choose a PCP on enrollment, a PCP is automatically assigned.



Humana can identify a member's previous PCP and family assignment (if applicable) within our participating PCP panel and assign via auto-assignment. Geographic assignment is used when a member has no record of a past PCP relationship. Our system ensures the auto-assigned PCP provides age-appropriate services for the member.

Members can change to another participating PCP as often as needed. PCP changes are processed within 30 days of the change request. PCP changes are made effective the first day of the following month.

Provider responsibilities

*Please note that this section is not all-inclusive of all provider responsibilities.

Access-to-care requirements

You must offer hours of operation that are no less than the hours of operation offered to individuals who are not members. Participating PCPs, BH providers and specialists are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week and should not discriminate against members. An after-hours telephone number must be available to enrollees/members (voicemail is not permitted). Members should be triaged and provided appointments for care within the time frames outlined in the table below:

Appointment type	Required time frame from date of request
Urgent medically necessary care	Within 1 business day
Not urgent, but medical attention required	Within 7 business days
Routine PCP and BH sick member care	21 calendar days
Initial prenatal visits without expressed problems	**First trimester:** within 14 calendar days **Second trimester:** within 7 calendar days **Third trimester:** within 3 calendar days
Initial appointment for outpatient treatment for mental, emotional, nervous or substance use disorders or conditions	Within 10 business days
Follow-up appointments for outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions	Within 20 business days
Referral and immediate linkage of members who remained in the community following a BH crisis event with an urgent appointment with a mental health provider	Within 1 business day after the BH crisis event, if deemed medically necessary
Routine, preventive care	Within 5 weeks

Critical incident reporting

You are required to implement a systematic process for incident reporting and immediately (i.e., or no later than 24 hours after occurrence) notify Humana of any incident that may jeopardize the health, safety and welfare of an enrollee or impair continued service delivery. Reportable conditions include, but are not limited to:

- Closure of provider services or facilities due to license violations
- Loss or destruction of enrollee records
- Compromise of data integrity
- Fire or natural disasters
- Critical incidents or adverse events that affect an enrollee's health, safety and welfare

Report critical incidents, unexplained deaths or unplanned hospitalizations to the enrollee's Humana care manager via the Humana Provider Services line at 800-787-3311, Monday – Friday, 8 a.m. – 8 p.m., Central time.

Abuse, neglect and exploitation should be reported to the appropriate agency below:

- Adult Protective Services: 866-800-1409, 24 hours a day, 7 days a week
- Illinois Office of the Inspector General: 844-ILFRAUD (844-453-7283), 24 hours a day, 7 days a week
- Supportive Living Facility Complaint Hotline: 800-226-0768, 24 hours a day, 7 days a week
- Nursing Home Complaint Hotline: 800-252-4343, 24 hours a day, 7 days a week

Participation in Humana's Quality Improvement Program

Through our Quality Improvement Program, we monitor and evaluate the quality and appropriateness of (or failure to provide) member care and service delivery through the methods outlined below:

Quality improvement projects

Ongoing measurements and interventions that help improve care quality and service delivery in both clinical care and nonclinical areas; known to have a favorable effect on health outcomes and member satisfaction

Medical record audits

Annual medical record review conducted by an External Quality Review Organization to evaluate quality outcomes concerning the timeliness of, and enrollee access to, covered services

Performance measures

Data on patient outcomes as defined by Healthcare Effectiveness Data and Information Set (HEDIS®) or otherwise defined by the National Committee for Quality Assurance (NCQA)

Access-to-care audits

Assembly of randomly selected providers to gauge appointment and after-hours answering service availability while identifying opportunities to improve appointment access

Surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Provider Satisfaction Survey

Peer review

Conducted by Humana to review provider practice methods, patterns and appropriateness of care

Americans with Disabilities Act requirements

You are required to comply with all Americans with Disabilities Act (ADA) requirements, including providing:

- Waiting room and exam room furniture that meets the needs of all enrollees, including those with physical and nonphysical disabilities
- Interpretation services for enrollees with limited English proficiency and auxiliary aids for hearing and visually impaired enrollees
- Clear signage throughout the care setting
- Adequate provider office parking and access for enrollees

Cultural competency requirements

Cultural competence refers to the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to improve the quality of services with the intention of producing better outcomes.

Cultural humility refers to the ability of organizations, systems and healthcare professionals to value, respect and respond to diverse cultural health beliefs and practices, behaviors and needs (e.g., social, cultural, linguistic) when providing equitable healthcare services.

For more information about how you can practice cultural competency and cultural humility, please review our **Cultural Humility, Health Equity and Implicit Bias Training** for providers. Sign in to **Availity Essentials** and select **Payer Spaces > Humana > Humana Learning Center** to get started.

Reporting demographic changes

To ensure your information is properly listed in the provider directory and all payments are made in a timely manner, you must notify us of demographic changes, including:

- Change to your Tax Identification Number (TIN)
- Providers joining or leaving the group
- Service address updates (e.g., new location, phone or fax)
- Access to public transportation
- Standard hours of operation and after-hours availability
- Billing address updates
- Credentialing updates
- Panel status
- Gender
- Languages spoken in office

Reporting demographic changes (cont'd.)

Non-BH providers can report demographic changes to Humana by:

- Calling Provider Relations at 800-626-2741, Monday – Friday, 8 a.m. – 5 p.m., Central time.

BH providers can report demographic changes to Carelon by:

- Visiting the CAQH portal (our preferred method)
  - Participating CAQH providers: **Log in to your CAQH ProView**
  - New users: **Register for CAQH ProView**
- Visiting the Carelon Provider Portal
  1. Log in to Carelon's **provider portal**
  2. Select "Update Demographic Information"
- Calling the Carelon National Provider Service Line at 800-397-1630, Monday – Friday, 7 a.m. – 7 p.m., Central time

Community outreach requirements

- Healthcare providers **may** display health-plan-specific materials in their own offices in common areas only, such as entryways, waiting rooms, cafeterias, or community or conference rooms.
- Healthcare providers **may** provide information and assistance in applying for the Low Income Subsidy (LIS).
- Healthcare providers **cannot** compare benefits or provider networks among health plans—orally or in writing—other than to confirm participation in a health plan's network.
- Healthcare providers **may** announce a new affiliation with a health plan and give patients a list of health plans with which they contract.
- Healthcare providers **may** cosponsor events such as health fairs and advertise with the health plan in indirect ways, such as television, radio, posters, flyers and print advertisements.

Community outreach requirements (cont’d.)

- Healthcare providers **cannot** furnish patient lists to the health plan with which they contract, or to any other entity.
- Healthcare providers **cannot** furnish other health plans' membership lists to the health plan with which they contract.
- Healthcare providers **cannot** assist with health plan enrollment.
- Healthcare providers **may** distribute health plan information about:
  - Non-health plan-specific healthcare services
  - Health, welfare and social services by the state or local communities
- Healthcare providers **must** refer all inquiries from prospective members to the enrollee services section of the health plan or the agency‘s choice counselor/enrollment broker.

Section 1557 requirements

Providers who operate a health program or activity and receive federal financial assistance from the Department of Health and Human Services (HHS) for any part of that program or activity are required to comply with Section 1557 of the Affordable Care Act (ACA). Requirements include posting:

- A nondiscrimination statement in provider offices
- A notice about nondiscrimination and accessibility requirements

Helpful links:

- **Training materials for Section 1557**

Provider training

Humana supports you in your efforts to provide care to patients with FIDE-SNP coverage by offering training materials to help you meet state and federal compliance requirements.

- Humana Illinois FIDE-SNP provider compliance training (this training)
- Humana Illinois FIDE-SNP clinical provider training
- Health, safety and welfare training
- Cultural competency training
- General compliance and fraud, waste and abuse training

Training is available through **Availity Essentials** :

- Sign in to **Availity Essentials** and select **Payer Spaces** > **Humana** > **Humana Learning Center**
- Select the category Compliance trainings
- Search for the current year training by state (for any state-[s] in which you are contracted).

If you have not yet registered with **Availity Essentials** , **this document** will guide you through the process to register and get started with Availity Essentials.

Availity Essentials offers free product training. Sign in to Availity Essentials and select Help & Training to get started.

Claims

Timely filing

Claims are not paid if they have incomplete, incorrect or unclear information. Healthcare providers are required to file claims/encounters on time for all services rendered to members. Timely filing is an essential component reflected in HEDIS reporting. It ultimately affects how a plan and its providers are measured in preventive member care and screening compliance. Timely filing requirements are outlined below.

- Claims that do not involve a third-party payer for services rendered must be submitted within 90 calendar days of the date of service or from discharge for in-network providers, and 6 months from the date of service or from discharge for out-of-network providers.
- Humana's timely filing limits for your claims are within 90 calendar days of the date of the claim's recovery or recoupment notice from the previous payer. This timely filing requirement is waived in cases of member retroactive coverage. If a claim is denied for Coordination of Benefits (COB) information needed, you must submit the appropriate remittance statement from the primary payer within the remainder of the initial claim timely filing period.

Electronic claim submission

Humana accepts electronic claims through these clearinghouses*:

- **Availity Essentials**
- **Change Healthcare®**
- **TriZetto®**
- **SSI Group**

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

- **61101** for non-capitated fee-for-service claims
- **61102** for capitated encounter claims
- **61105** for delegated encounter claims
- **BHOVO** for Carelon BH claims

BH claims should be submitted electronically via **Carelon Behavioral Health eServices**.

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

Paper claim submission

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

Medical claims

Humana Claims Office
P.O. Box 14359
Lexington, KY 40512-4359

LTSS

Humana Claims Office
P.O. Box 14359
Lexington, KY 40512-4359

Behavioral health

Carelon Behavioral Health
P.O. Box 1866
Hicksville, NY 11802-1866

Encounters

Humana Claims Office
P.O. Box 14055
Lexington, KY 40512-4055

Availity Essentials

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

- Patient management
- Claim management and status
- Provider engagement
- Authorization and referral management
- Electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollment

Sign in to **Availity Essentials** (registration required).

From the Payer Spaces menu, select Humana.

From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator.)

Provider self-service portal from Humana

Claims status and edit information on Availity Essentials

You can access the following information via Availity Essentials:

- 18 months of claims history
- Claims details
- Code Editing Simulator tool to receive instant response about code edits that may be applied

You can also do the following via Availity Essentials:

- Export your search results
- Correct claims online
- Add attachments
- View 835 remittance advice
- Download Health Insurance Portability and Accountability Act of 1996 (HIPAA) X12 formats

How to avoid common claim submission errors

Common rejection or denial reasons:

- Patient not found
- Subscriber not found
- Patient birthdate on the claim does not match the date of birth 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 authorization and/or referrals for rendered services

Claim processing and payments

Claims processing

Humana processes accurate and complete provider claims in accordance with our normal claims processing procedures, including **claims processing edits**, **claims payment policies**, and applicable state and/or federal laws, rules and regulations.

Claims payments

By enrolling in EFT and ERA for claims payments, you can get paid up to 7 days faster than via mail and reduce administrative paperwork as well as the risk of lost or stolen checks. When you enroll in EFT and ERA, Humana claim payments are deposited directly into the bank account(s) of your choice and you receive HIPAA-compliant ERA transactions. Remittances are sent to your clearinghouse or you can view them online. You can use the Humana ERA/EFT enrollment tool on the **Availity Essentials** provider portal. To access this tool:

1. Sign in to **Availity Essentials**
2. From the Payer Spaces menu, select Humana.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator to discuss your need for this tool.)

To learn more, call Availity Essentials at 800-282-4548, Monday – Friday, 7 a.m. – 7 p.m., Central time or visit **Availity Essentials** online.

Overpayments

You must notify us when you receive an overpayment from us and return it within 60 calendar days of identifying it. You must notify us in writing of the specific reason for the overpayment and how you identified the overpayment.

Humana provides written notice at least 30 business days before an adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment are made on a subsequent reimbursement.

Please mail refund checks for overpayments to:

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

Refund checks for BH overpayments should be sent to:

Humana Healthcare Plans
5800 Northampton Blvd.
Norfolk, VA 23502

Prohibition of balance billing

- You must not balance bill members, bill for missed or cancelled appointments, or collect coinsurance, copayments, deductibles, financial penalties or any other amount, in full or part, for any covered service.
- State requirements and federal regulations prohibit providers from billing Humana members for medically necessary covered services except under very limited circumstances.
- Humana monitors this billing policy activity based on complaints of billing from members. Failure to comply with regulations after intervention may result in criminal charges and termination of your agreement with Humana.
- In the event Humana issues a payment denial for rendered services to an member due to lack of medical necessity, you cannot bill, charge, seek payment or have any recourse against the member for such services.

Provider claim disputes for non-BH claims

Provider disputes: If you disagree with the initial claim determination made by Humana, you may request a dispute/reopening of the issue. You may submit disputes online through Availity Essentials or by contacting us via telephone, written correspondence or fax as outlined below.

Step 1:

Call 800-787-3311, Monday – Friday,
7 a.m. – 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 was not adequately addressed by the call center representative, you have the option to speak to a call center supervisor. Based on availability, you are connected to a supervisor, or a supervisor contacts you within 48 hours of your request.

or

Submit a written claim dispute via:

Mail: **Humana Provider Correspondence**
P.O. Box 14359
Lexington, KY 40512-4359

Fax: 888-599-2730

When submitting a written claim dispute, include a copy of the original claim, the remittance notification showing the denial, and any clinical records or other documentation that support your case for reimbursement.

Provider claim disputes – for non-BH claims (cont'd.)

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**.

Note: The reference number received from Step 1 MUST be included in the request to Humana Provider Services.

For more information, please visit **Humana's claim-payment inquiries webpage**.

You will receive regular updates about your inquiry after you send an email to **HumanaProviderServices@humana.com**.

Provider claim disputes for BH claims

BH providers may submit disputes by phone, email or fax:

- Phone: 844-231-7949
- Email: **WoburnClaimAppeals@carelon.com**
- Fax: 781-994-7636

Disputes submitted by phone do not automatically generate a reference number if Provider Services can address the complaint during the call. However, a tracking number can be provided on request.

Claims resources

On our **coverage and claims webpage**, you can locate information about:

- Electronic claim submissions
- Claim coding guidelines
- Claim processing edits

Care management

Model of care

As provided under section 1859(f)(7) of the Social Security Act, every SNP, including FIDE-SNPs, must have a model of care (MOC) approved by NCQA. The MOC provides the basic framework under which each SNP meets patient needs. It serves as the foundation for promoting SNP quality, care management and care coordination processes.

Humana's MOC has 4 goals:

- To improve member outcomes by coordinating care and ensuring care transitions
- To improve member access to and utilization of services and benefits
- To increase member's satisfaction with their healthcare experience and health status
- To ensure cost-effective service delivery

Humana achieves these goals by:

- Conducting Health Risk Assessments to identify risk needs
- Developing a plan of care to address identified needs
- Providing access to an interdisciplinary care team

Per The Centers for Medicare & Medicaid Services (CMS) guidelines, all contracted providers serving SNP members must review and attest to our SNP annual training, which includes information on our MOC. To access the training and obtain additional information about the model, please refer to **Humana's compliance training**. For more information on our Illinois FIDE-SNP model of care, please review the care management chapter of the **Humana Illinois FIDE-SNP Provider Manual**.

Care management overview

Humana uses a holistic and fully integrated health management program to address a member's physical and BH needs as well as health-related social needs. Our care management process includes the following steps:

1. We identify members for participation in our care management programs through referrals from on-site/telephonic UM nurses, PCPs, specialists, enrollee self-referrals, a health needs assessment, predictive model algorithms, post discharge assessments, etc.
2. Humana obtains the member's agreement to participate. Enrollees may opt out anytime.
3. We assign the member a care coordinator.
4. The care coordinator conducts a health screening assessment within 30 days after enrollment to determine the member's risk level—low, moderate or high.
5. The care coordinator develops an interdisciplinary care plan (ICP) after the first 15 days after enrollment based on the member's risk level.
6. The care coordinator works closely with the member's PCP to develop and lead an interdisciplinary care team (ICT).

Enrollee care plans and screening assessments are viewable, with enrollee/member consent, via **Availity Essentials**. You can refer enrollees for care management via email to **HAH_ProviderReferrals@humana.com**.

LTSS members are auto-enrolled into care management and have a care manager assigned on enrollment. LTSS care management creates an ICP and service level plan for home- and community-based services (HCBS) members.

Continuity of care

Humana honors previously approved authorizations for at least 90 calendar days from the member's enrollment date.

Humana pays for covered services rendered by a non-network provider during the 90-day transition period at the same rate paid for such services under the Illinois Medicaid fee for service (FFS) methodology.

Non-network providers and specialists providing an ongoing course of treatment are offered agreements to continue to care for an individual member on a case-by-case basis beyond the transition period if the provider remains outside the network or until a qualified network provider is available.

Clinical management programs

Designed to:

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

To learn more, visit **Humana's health and wellness resource webpage**.

Utilization management

Utilization management

Utilization management helps maintain the quality and appropriateness of healthcare services provided to Humana members.

- Includes prior authorization, concurrent reviews, discharge planning and other activities such as monitoring inpatient and outpatient admissions
- Reviews medical necessity, appropriateness of care and service, and existence of coverage
- Limits a service based on criteria applied under the Medicaid state plan and applicable regulations, such as medical necessity

Prior authorization

Prior authorization is required for many services and medications. You can determine what medications and services require prior authorization by visiting **Humana's Prior Authorization Lists webpage** and selecting the appropriate list.

To obtain prior authorization for medical procedures, you may call 800-523-0023. You should have your TIN available. You may also request authorization for non-LTSS services through Availity. LTSS authorizations are facilitated by care coordinators and can be requested by emailing **HUMLTSSTransitions@humana.com**.

To obtain prior authorization for medications, you may fill out the appropriate forms on **Humana's prior authorization list** or call 800-555-CLIN (2546), Monday – Friday, 7 a.m. – 10 p.m., Central time.

To obtain prior authorization for drugs delivered/administered in a provider's office, clinic, outpatient or home setting, you may fill out the appropriate form as directed on our **prior authorization for professionally administered drugs webpage** or call 866-461-7273, Monday – Friday, 7 a.m. – 5 p.m., Central time.

To obtain prior authorization for BH services, for the acute and diversionary levels of care, call 855-371-9234 for live telephonic review. Authorization for outpatient levels of care can be requested via fax by completing an Outpatient Request Form. This form is available on **Carelon's website**.

Referrals and second opinions

Referrals

A referral is an authorization provided by a PCP to enable a member to seek medical care from another provider. Humana has policies and procedures to guide PCP referrals to ensure timely, appropriate care for a member's condition.

Humana requires referrals from PCPs to see participating specialists, with the exception of some specialist types including OB-GYNs. However, prior authorization must be obtained for nonparticipating providers.

Second opinions

At members request, Humana provides for a second opinion from a qualified healthcare professional within our provider network or arranges for the member to obtain one outside the provider network, at no cost to the member.

The provider offering the second opinion must practice in an appropriate specialty to provide a second opinion and must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.

Retrospective reviews

You must obtain prior authorization prior to rendering services. Humana does not pay claims in which authorization is required but not obtained, unless certain circumstances are met. In these circumstances, Humana conducts retrospective reviews to determine whether to grant authorization for services in which authorization was not obtained prior to the service being rendered.

You have 14 calendar days from the date of service or inpatient discharge date or receipt of the primary insurance carrier's explanation of payment to request a retrospective review for medical necessity. Requests for retrospective review that exceed these time frames are denied and are ineligible for appeal.

You can submit a retrospective review request via **Availity Essentials**, call 800-282-4548, Monday – Friday, 7 a.m. – 7 p.m., Central time, or fax 833-845-9102.

You can submit a retrospective review request for BH services by sending your treatment notes, assessment and chart for the level of care you are requesting via mail to:

Carelon Behavioral Health
P.O. Box 1856
Hicksville, NY 11802-1856

Member grievances and appeals

Member grievances and appeals

Grievances

- Members or their authorized representatives can file a grievance anytime, orally or in writing, if they are dissatisfied with Humana or any aspect of their care.
- Humana resolves the member's grievance as quickly as the member's health condition requires.
- Grievances are resolved within 30 business days from the date Humana receives the request.

Appeals

- members or their authorized representatives can file an oral or written appeal if they are dissatisfied with an adverse benefit determination. The appeal must be filed within 65 calendar days of the date on the adverse benefit determination letter. Humana resolves appeals as quickly as the member's health condition requires.
- Humana may extend the time frame for appeals, other than for Part B drugs, by up to 14 calendar days if the member requests an extension or if Humana needs more information and extending the time frame is beneficial to the member.

Standard appeals

- Standard appeals, other than for Medicare Part B drugs, are resolved no later than 14 calendar days from the date Humana receives the request.
- Standard appeals for Part B drugs are resolved within 7 calendar days from the date Humana receives the request.

Expedited appeals

- If the member's life, physical or mental health, or ability to attain, maintain or regain maximum function would be at risk following the standard appeal time frame, an expedited appeal can be requested.
- Expedited appeals are resolved no later than 24 hours after receipt of the required information, within a maximum of 72 hours after receiving the appeal request.

To file a grievance or appeal:

Mail

Humana
P.O. Box 14163
Lexington, KY 40512-4163

Enrollee Services
Call Member Services at 800-787-3311 (TTY: 711), Monday – Friday, 8 a.m. – 8 p.m., Central time

Members can request assistance from Member Services at 800-787-3311 (TTY: 711).

Independent Review Entity

If an appeal decision involving Medicare services or overlapping Medicare/Medicaid services is not fully in the member's favor, Humana automatically forwards the appeal to the Independent Review Entity (IRE), Maximus, for review.

- For standard appeals, except those regarding Part B drugs, the IRE will send the member a decision letter within 30 calendar days after it receives the case from Humana.
  - A payment decision is issued within 60 calendar days.
- For expedited appeals, the IRE sends the member a decision letter within 72 hours after it receives the case.
- For expedited appeals regarding Part B drugs, if the IRE decides in the member's favor, then Humana authorizes or provides the Part B drug under dispute as quickly as the member's health condition requires, but no later than 24 hours from the time Humana receives notice of the IRE's decision.
- If the IRE's decision is not fully in the member's favor, the member or their authorized representative can request a further level of appeal, including a Medicaid State Fair Hearing. For Medicare benefits, members can request review by an administrative law judge with the Department Appeals Board along with a judicial fair hearing.

Medicaid State Fair Hearing

If an appeal decision involving Medicaid benefits is not fully in the member's favor, the member or the member's authorized representative can appeal to the Illinois Department of Human Services by requesting a State Fair Hearing. Medicaid State Fair Hearing requests must be filed within 120 calendar days from the date on Humana's appeal decision letter.

To request a State Fair Hearing:

Call: Illinois Department of Human Services at 855-418-4421 (TTY: 800-526-5812)
Fax: 312-793-2005
Email: **HFS.FairHearing@illinois.gov**

Mail State Fair Hearing requests to:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington St., 4th floor
Chicago, IL 60602

Administrative law judge review

If an appeal decision involving Medicare benefits is not fully in the member's favor, the member or the member's authorized representative can appeal to the Departmental Appeals Board. Any further review occurs in federal court.

If an appeal decision involving Medicaid benefits is not fully in the member's favor, the member or the member's authorized representative can appeal to state circuit court.

Covered services

Covered services

Humana offers a variety of benefits. Covered services include, but are not limited to:

- Advanced practice nurse services
- Ambulatory surgical treatment center services
- Assistive/augmentative communication devices
- Audiology services
- Blood, blood components and the administration thereof
- Chiropractic services
- Dental services, including oral surgeons
- Family planning services and supplies
- FQHCs, RHCs and other encounter rate clinic visits
- Home health agency visits
- Hospital emergency room visits
- Hospital inpatient services
- Hospital ambulatory services
- Laboratory and X-ray services
- Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies
- Mental health services
- Nursing care
- Nursing facility services
- Optical services and supplies
- Optometrist services
- Palliative and hospice services
- Pharmacy services
- Podiatric services
- Post-stabilization services
- Renal dialysis services
- Respiratory equipment and supplies
- Services to prevent illness and promote health
- Subacute alcoholism and substance use services
- Transplants
- Transportation
- Transportation to secure covered services

For a longer list of covered services, please review the the **Humana Illinois FIDE-SNP Provider Manual**.

Medical transportation management

Medical transportation management (MTM) provides nonemergency transportation for:

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

Depending on medical conditions and locations, enrollee transportation can include the following forms of transportation:

- Taxi
- Bus
- Van
- Subway
- Wheelchair vehicle
- Stretcher van
- Medical transport

Curb-to-curb service is provided. Transportation drivers cannot enter homes or medical facilities. If medically necessary, 1 escort (18 or older) can accompany a member when space is available.

When possible, transportation should be scheduled at least 2 business days in advance by calling 855-253-6867, Monday – Friday, 8 a.m. – 8 p.m., Central time. When trips cannot be scheduled in advance (such as return trips from medical appointments), members can still call MTM at 855-253-6867. TTY users can dial 711 to access the local MTM provider.

Members also can schedule transportation via the MTM member portal, 24 hours a day, 7 days a week on **the enrollee portal website**.

You can help members schedule trips via the **MTM facility portal**.

Go365 wellness and rewards program

Go365 by Humana® is a wellness program for qualifying members that gives them the opportunity to earn rewards for completing healthy actions, including getting preventive screenings and staying active.

Providers must submit claims to help members earn their rewards.

A listing of healthy activities members complete to earn rewards can be found in the Humana Illinois FIDE-SNP Provider Manual at Link to **Provider Manual**.

Behavioral health

Behavioral health

Humana contracts with Carelon Behavioral Health to delegate behavioral health (BH) functions including:

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

Contact information for Carelon Behavioral Health

BH providers can get more information on BH services through the Carelon Behavioral Health provider portal, Carelon eServices, or by emailing Carelon Behavioral Health at **provider.relations.IL@carelon.com**.

- For information about electronic data interchange and electronic claims, sign into **Carelon eServices**. For an EDI companion guide, please email **provider.relations.IL@carelon.com**.
- You also can call Carelon's interactive voice response (IVR) line at 855-481-7044 to reach provider relations and clinical staff. When you call this phone number, please have your organization's TIN, the member's ID number, the member's date of birth and the date of service. Providers can check enrollee eligibility, contracting/credentialing, claims and claims status and more through the IVR line, or speak with an agent for assistance.

Contact information for Carelon Behavioral Health (cont'd.)

Provider portal: BH providers can access information and resources through the **Carelon Behavioral Health provider portal**.

National provider service line: Whether you have a question or are interested in learning more about how we can best support you, please call our national provider service line at 800-397-1630, Monday – Friday, 7 a.m. – 7 p.m., Central time.

Email: For direct inquiries or additional information, please contact Carelon's Provider Relations team via email at **provider.relations.IL@carelon.com**.

IVR: For further assistance, you can call Carelon's IVR system at 855-481-7044. When calling, please have the following information ready:

- Organization's TIN
- Member's ID number
- Member date of birth
- Date of service

The IVR system offers prompts for:

- Member eligibility
- Contracting/credentialing
- Claims information
- And more

Providers also can check claim status through the IVR self-service feature.

Fraud, waste and abuse

Fraud, waste and abuse definitions

Healthcare fraud, waste and abuse can involve providers, pharmacists, members and medical equipment companies. Success in combating healthcare fraud, waste and abuse is measured not only by convictions, but also by effective deterrent efforts. See definitions for these terms below.

Fraud

Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program. (18 U.S.C. § 1347).

Waste

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Abuse

Abuse is payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.

The federal government and individual states establish and monitor requirements designed to reduce fraud, waste and abuse. Additional information about fraud, waste and abuse is available in a CMS-published training, **Combating Medicare Parts C and D Fraud, Waste, and Abuse**. Its concepts also apply to Medicaid.

Requirements for reporting fraud, waste and abuse concerns

Anyone who suspects or detects a fraud, waste or abuse violation is required to report it either to Humana or within their respective organization, which should then forward the information to Humana.

Key features of reporting directly to Humana:

- **Anonymity:** If the person making the report chooses to remain anonymous, they are encouraged to provide enough information about the suspected violation (e.g., date[s] and person[s], system[s] and type[s] of information involved) to allow Humana to review the situation and respond appropriately.
- **Confidentiality:** Processes are in place to maintain confidentiality of reports; Humana allows confidential report follow-up.

Humana strictly prohibits intimidation and/or retaliation against anyone who, in good faith, reports suspected or detected violation of ethical standards.

Any entity supporting Humana that offers a reporting option to its employees and downstream entities must provide 24/7 access and the same key features outlined here.

Methods for reporting fraud, waste and abuse concerns

Anyone who suspects or detects a fraud, waste and abuse violation is required to report it either to Humana or within their respective organization, which should then forward the information to Humana.

Contacts for reporting fraud, waste and abuse:

- SIU hotline:
  800-614-4126
  (24/7 access)
- SIU email:
  siureferrals@humana.com
- SIU fax:
  920-339-3613

- Ethics Help Line:
  available 24/7 via phone or web
  - Ethics Help Line:
    877-5 THE KEY
    (877-584-3539) (24/7 access)
  - Web: **www.ethicshelpline.com**
  - Email: **ethics@humana.com**

- **Mail to:**

  Humana
  Special Investigation Unit
  1100 Employers Blvd.
  Green Bay, WI 54344

Long-term services and supports

Introduction to long-term services and supports

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

A Humana member, family member or healthcare 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 (NFLOC). LTSS eligibility is determined by the state.

HCBS waiver types

- Elderly (age 60 and older)
- Physically disabled (age 60 and younger)
- Brain injury
- HIV/AIDS
- Supported-living facility

More information can be found in your provider manual, available at Link to **Provider Manual**.

Overview of waiver programs

Illinois waiver programs provide services that allow individuals to remain in their own homes or live in a community setting. Each waiver offers support for groups of affected individuals which enables them to address their specific needs with appropriate services.

Medicaid waivers are determined by IDoA, Department of Rehabilitation Services (DRS) and DHS.

Once an enrollee becomes eligible, a determination of needs (DON) score is assigned to determine the member's level of need. The member is then enrolled in a waiver program.

More information can be found in your provider manual, available at Link to **Provider Manual**.

Available waiver programs

Persons who are elderly waiver

IDOA operates this waiver program for individuals who are 60 or older and who are otherwise eligible for or are at-risk for NFLOC as evidenced by a DON.

Persons with disabilities waiver

DRS operates this waiver program for individuals with disabilities 59 and younger (those aged 60 or older who began services before age 60 may choose to remain in this waiver). MCO waiver eligibility requires that the member be severely disabled for at least 12 months or lifelong and be eligible for or at-risk of NFLOC as evidenced by a DON.

Person with HIV or AIDS waiver

DRS administers this waiver program for people of all ages diagnosed with HIV or AIDS who are at-risk of hospital or NFLOC as evidenced by a DON.

More information can be found in your provider manual, available at Link to **Provider Manual**.

Available waiver programs (cont'd.)

Person with brain injury/traumatic brain injury waiver

DRS administers this waiver program for people of all ages with a brain injury, including traumatic brain injury (TBI), infection (encephalitis, meningitis), anoxia, stroke, aneurysm, electrical injury, malignant or benign neoplasm of the brain and toxic encephalopathy, resulting in functional limitations. This disability must be severe and expected to last for at least 12 months or be lifelong, placing the member at-risk of placement in a nursing facility as evidenced by a DON.

Supportive living program waiver

IDHFS operates this waiver program for people aged 65 and older or persons with disabilities (as determined by the Social Security Administration [SSA]) aged 22 and older. Individuals screened by IDHFS, who are assessed and qualify for NFLOC services and are also eligible for a supportive living program, are eligible. Individuals must not have a primary or secondary diagnosis of developmental disability or serious and persistent mental illness. Finally, an individual's income must be equal to or greater than current supplemental security income and they must contribute all but $90 toward lodging, meals and services. Food stamp benefits may be used toward meal costs.

More information can be found in your provider manual, available at Link to **Provider Manual**.

Waiver service eligibility

Waiver services	Elderly	Disability	HIV/AIDS	Brain injury	Supportive living program
Adult day service and transportation	☑	☑	☑	☑	
Assisted living					☑
Automated medication dispenser	☑				
Behavioral services				☑	
Environmental accessibility adaptations – home		☑	☑	☑	
Habilitation – day				☑	
Home delivered meals		☑	☑	☑	
Home health aide		☑	☑	☑	
Homemaker	☑	☑	☑	☑	
Individual provider		☑	☑	☑	
Skilled and intermittent and nursing		☑	☑	☑	
Occupational, physical and speech therapy		☑	☑	☑	
Personal emergency response system (PERS)	☑	☑	☑	☑	
Prevocational services				☑	
Respite		☑	☑	☑	
Specialized medical equipment and supplies		☑	☑	☑	
Supported employment				☑	

LTSS preauthorization and notification

- Only those services deemed medically necessary will be covered. All services require an authorization.
- Do not submit LTSS authorizations via Availity Essentials. Instead, submit the LTSS authorization request to **HUMLTSSTransitions@humana.com**.
- Each member is assigned a care coordinator who facilitates authorizations. Requests for personal emergency response systems must be submitted to care coordinators by sending an email to **HUMLTSSTransitions@humana.com**.
- If you want additional information regarding care coordination services, please call Humana Provider Services at 800-787-3311, Monday – Friday, 7 a.m. – 7 p.m., Central time.

Care coordination

After state approval, Humana sends a care coordinator to the member's home to determine functional needs, develop an individualized care plan and initiate a LTSS service plan. Care coordinators work with the member to determine type and duration of necessary waiver services, including:

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

More information can be found in your provider manual, available at Link to **Provider Manual**.

Claim submission requirements

- You are required to file claims on time for all services rendered to members.
- Timely filing is an essential component reflected in Humana's HEDIS performance.
- Fee-for-service claims should be filed as soon as possible and no later than 90 days post-service.

When filing an electronic claim, use the following payer ID: 61101

For fee-for-service claims (non-capitated)

Please visit **Humana's claim resources webpage** to learn more about electronic claim submission, claim coding guidelines, claim processing edits and more.

Availity Essentials

Availity Essentials is the preferred method for online transactions.

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

How to register

Learn how **to register and get started** with Availity Essentials

Join us for a training session

Log in to Availity Essentials> Help & Training > Get Trained to access Availity's Learning Center

Questions

Availity Essentials helps with registration and tools at 800-AVAILITY (800-282-4548), Monday – Friday, 7 a.m. – 7 p.m., Central time.

Electronic and paper claim submission

Availity Essentials is Humana's preferred clearinghouse, and there are no service fees when electronic claims are submitted for Humana enrollees. Other commonly used clearinghouses include Change Healthcare, TriZetto, and SSI Group.

Paper claims for LTSS services should be submitted to:

LTSS
Humana Claims Office
P.O. Box 14359
Lexington, KY 40512-4359

More information can be found in your provider manual, available at Link to **Provider Manual**.

Waiver program claims

To file a claim for services that Humana approved for one of the 5 HCBS waivers, waiver providers must register with IMPACT.

Many HCBS providers are considered ‘atypical’ by the IDHFS IMPACT system. These providers are not required to obtain an NPI. Atypical providers are defined by CMS as providers who do not provide healthcare.

Taxi service providers, home and vehicle modifications providers and respite service providers are examples of atypical providers that may be reimbursed by the Medicaid program.

Even if atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of healthcare and should not receive an NPI.

More information can be found in your provider manual, available at Link to **Provider Manual**.

IDHFS' Legacy Provider Number

When billing HCBS services, the provider should only use their IDHFS' Legacy Provider Number (Medicaid ID) and should NOT include an NPI on the claim.

Humana requires the IDHFS' Legacy Provider Number on the claim match the IMPACT Legacy Provider Number (Medicaid ID). Humana does not process claims if the number used does not match the corresponding IDHFS' Legacy Provider Number and IMPACT-registered categories of service, specialties, etc.

A valid Medicaid ID must be on the 837P Billing Provider Secondary Identification Loop 2010BB Loop in a REF01 Segment, qualified by 'G2' and the REF02 equal to the provider's Medicaid ID as registered in IMPACT for their respective waiver provider type.

More information can be found in your provider manual, available at Link to **Provider Manual**.

Categories of service

Although categories of service (COS) are not directly added to a claim submitted to Humana, the specialties and subspecialties registered in the IDHFS Provider IMPACT system are critical to accurate claims payment. If the appropriate specialty or subspecialties are not registered with IDHFS, claims are denied. You should confirm that the correct COS on file for your specialty/subspecialty type with IDHFS by reviewing the Provider Information Sheet provided by IDHFS.

Category of service	IMPACT subspecialty
090	Case management
091	Home maker
092	Agency providers PA, RN, LPN, Certified Nursing Assistant (CNA) and therapist
093	Individual providers PA, RN, LPN, CNA and therapist
094	Adult day service
095	Habilitation services
096	Respite care
097	Other HCFA-approved services
098	Electronic home response (EHR)/EHR installation

Always use billing codes and rates provided by IDHFS. You may **view the fee schedule online**.

More information can be found in your provider manual, available on Humana's Illinois **Medicaid provider website**.

Completing the CMS-1500

CMS-1500 forms can be purchased via a variety of approved suppliers, such as Office Depot. Fillable PDF versions also can be purchased through online vendors and completed on a computer. The completed form must be printed, signed and mailed.

Some healthcare provider types that bill on the CMS-1500 include:

- Adult day care
- Homemaker agency
- Home health agency
- Assistive technology
- Personal care agency
- Personal emergency response system
- Service facilitators
- Environmental modifications
- Private duty nurse

More information can be found in your provider manual, available at Link to **Provider Manual**.

Common reasons for rejection or denial

- Member name missing from patient credit file
- Insured subscriber not found
- Incorrect or missing Member ID or demographics
- Submission of an invalid Healthcare Common Procedure Coding System (HCPCS) code
- No authorization or referral found
- Missing or incorrect NPI number or TIN (as applicable)
- Authorization on file does not include ALL days and units billed
- Missing or incorrect service codes or dates
- Incorrect type of bill
- Wrong patient disposition (discharge status)
- Submitting incorrect occurrence (code and date span) and value codes

More information can be found in your provider manual, available at Link to **Provider Manual**.

How to avoid errors and payment delays

To avoid claim submission errors, please note the following:

- Ensure the accuracy of member information received and submitted
- Ensure completion and accuracy of all required claim form fields
- Obtain proper authorizations and/or referrals for rendered services
- Bill with the appropriate Homemaker Service Units as approved on the authorization
- Bill only for allowable limits on home-delivered meals: 2 meals = 1 unit; maximum = 1 unit per day
- Ensure using only your IDHFS' Legacy Provider Number (Medicaid ID) when billing HCBS and do not include an NPI on the claim
- Ensure the IDHFS' Legacy Provider Number on the claim matches the IMPACT Legacy Provider Number (Medicaid ID)

To avoid payment delays and expedite the processing of your claims, we kindly ask that you include the Service Facility NPI on all hospice claims. This detail is crucial for accurate and swift handling by our processing team.

More information can be found in your provider manual, available at Link to **Provider Manual**.

LTSS web resources

Humana Illinois FIDE-SNP **provider manual,** available at Link to 2026 **Provider Manual**

Illinois FIDE-SNP LTSS Link to 2026 **provider billing guide**

Illinois FIDE-SNP LTSS Link to 2026 **resource guide**

Humana Link to 2026 **claim-payment inquiry resolution guide**

Thank you

Humana®