



Humana.

Claims Education and Resolution
Humana Healthy Horizons
Indiana PathWays for Aging
2026 IHCP Works Annual Seminar



Agenda

01 | Welcome

02 | Team Overview

03 | Availity Registration

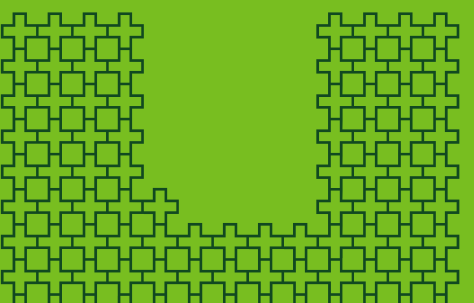
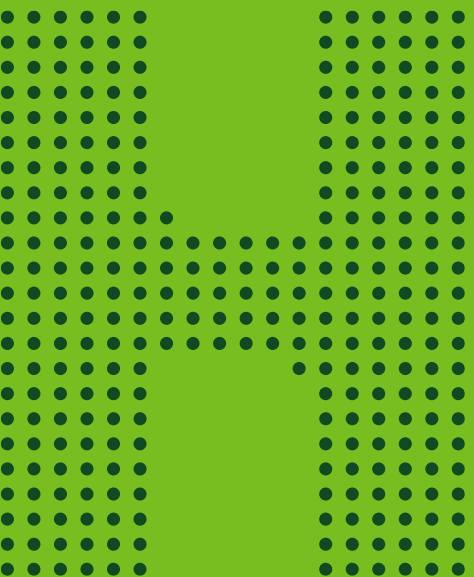
04 | Claim Recoupments/Overpayments

05 | Claims Overview

06 | Claims Submission

07 | Informal/Formal Disputes

08 | Q&A



Who We Are

The Claims Research and Resolution (CRR) 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.

Claim Inquiry Examples



Fee schedule errors

Participating/
nonparticipating provider
issues



Coordination of benefits
(COB) updates

Availity Essentials
rejections

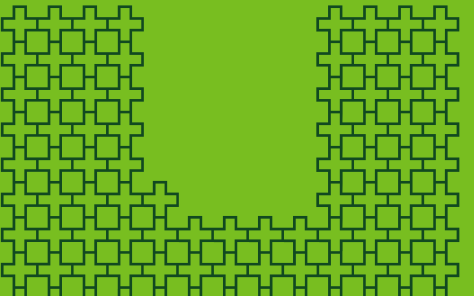
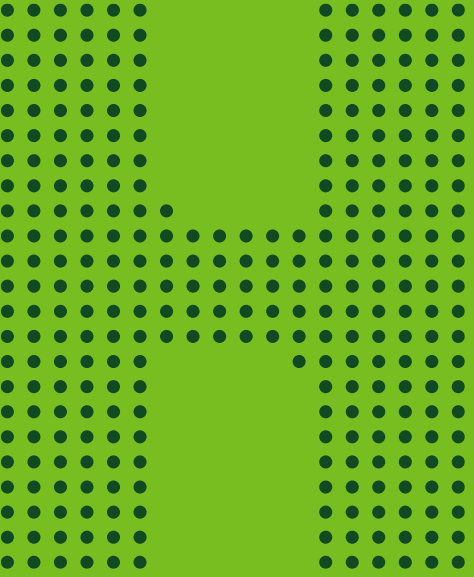
Claim denials



Wrap/encounter inquiries

LPI/Medicaid ID Inquiries

Taxonomy/National Provider
Identifier (NPI) inquiries



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

Region 3

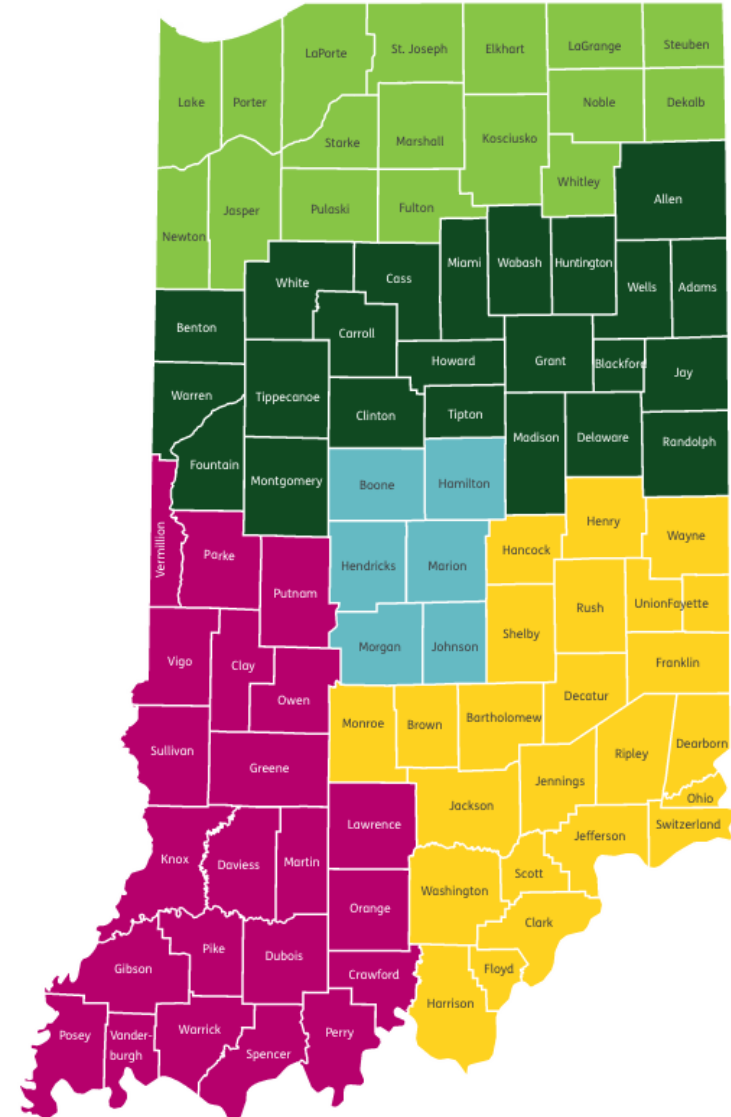
INLTSSProviderRelations T3@humana.com
Taylor Mitchell - (463) 265-2405
Bria Steele - (317) 677-2693

Region 4

INLTSSProviderRelations T4@humana.com
Mark Eastridge - (812) 697-8583

Region 5

INLTSSProviderRelations T5@humana.com
Kimberly Dunn - (812) 914-3104



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

Skilled Nursing Facilities

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

Hospice

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

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 Behavioral Health, Physical Health and Nursing Facility Provider Representatives Map for Indiana PathWays for Aging

Region 1

INMedicaidProviderRelations T1@humana.com
Brittani Fox - (219) 216-5588

Region 2

INMedicaidProviderRelations T2@humana.com
Jelaina Hollingsworth - (346) 236-4261

Region 3

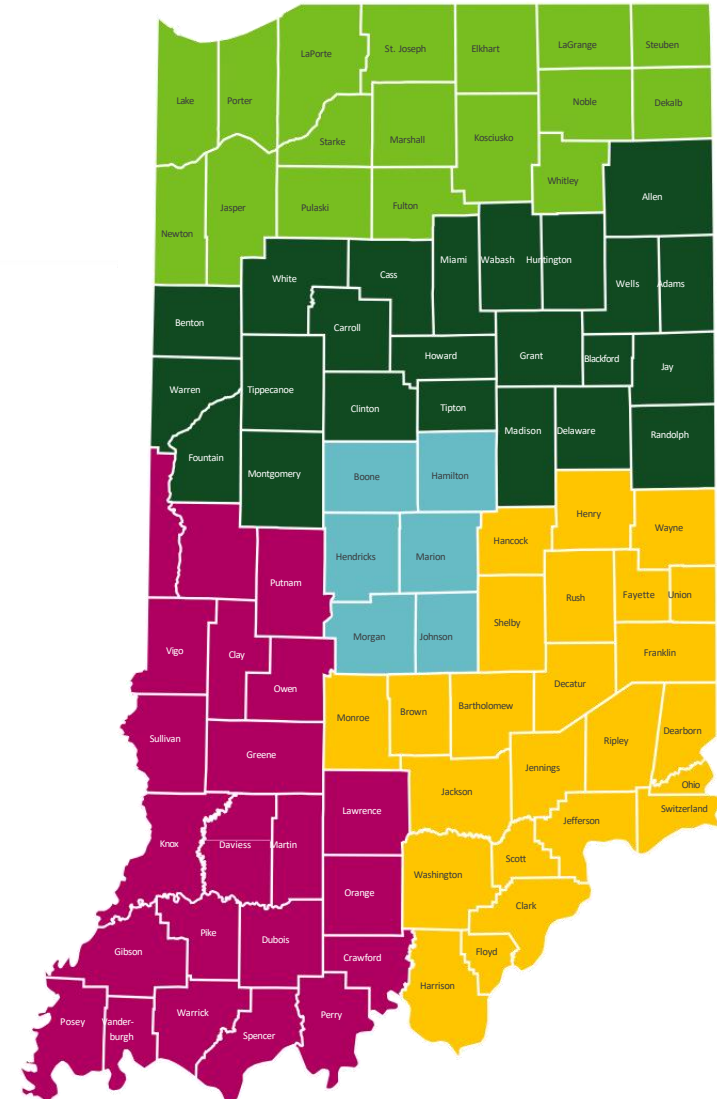
INMedicaidProviderRelations T3@humana.com
Jelaina Hollingsworth - (346) 236-4261
Hannah Lummis - (463) 324-6074

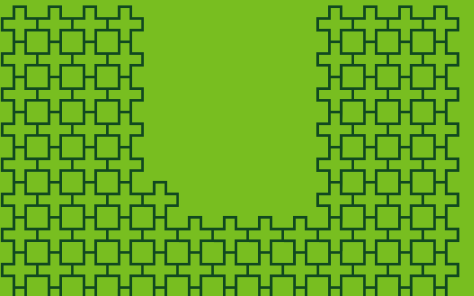
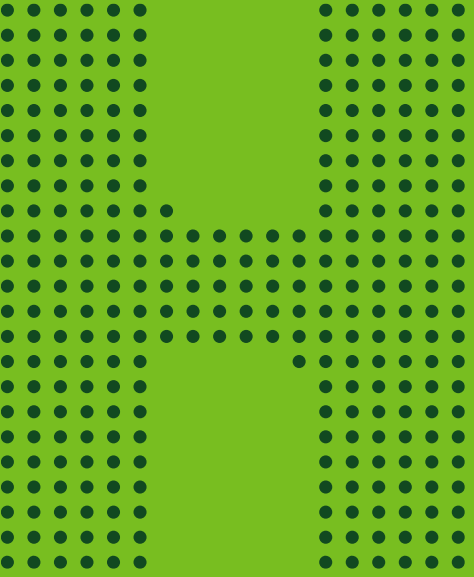
Region 4

INMedicaidProviderRelations T4@humana.com
Mychelle Christian - (812) 204-9285

Region 5

INMedicaidProviderRelations T5@humana.com
Mychelle Christian - (812) 204-9285





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 \(availity.com\)](http://www.availity.com)**

How to Register for Availity: HCBS Provider

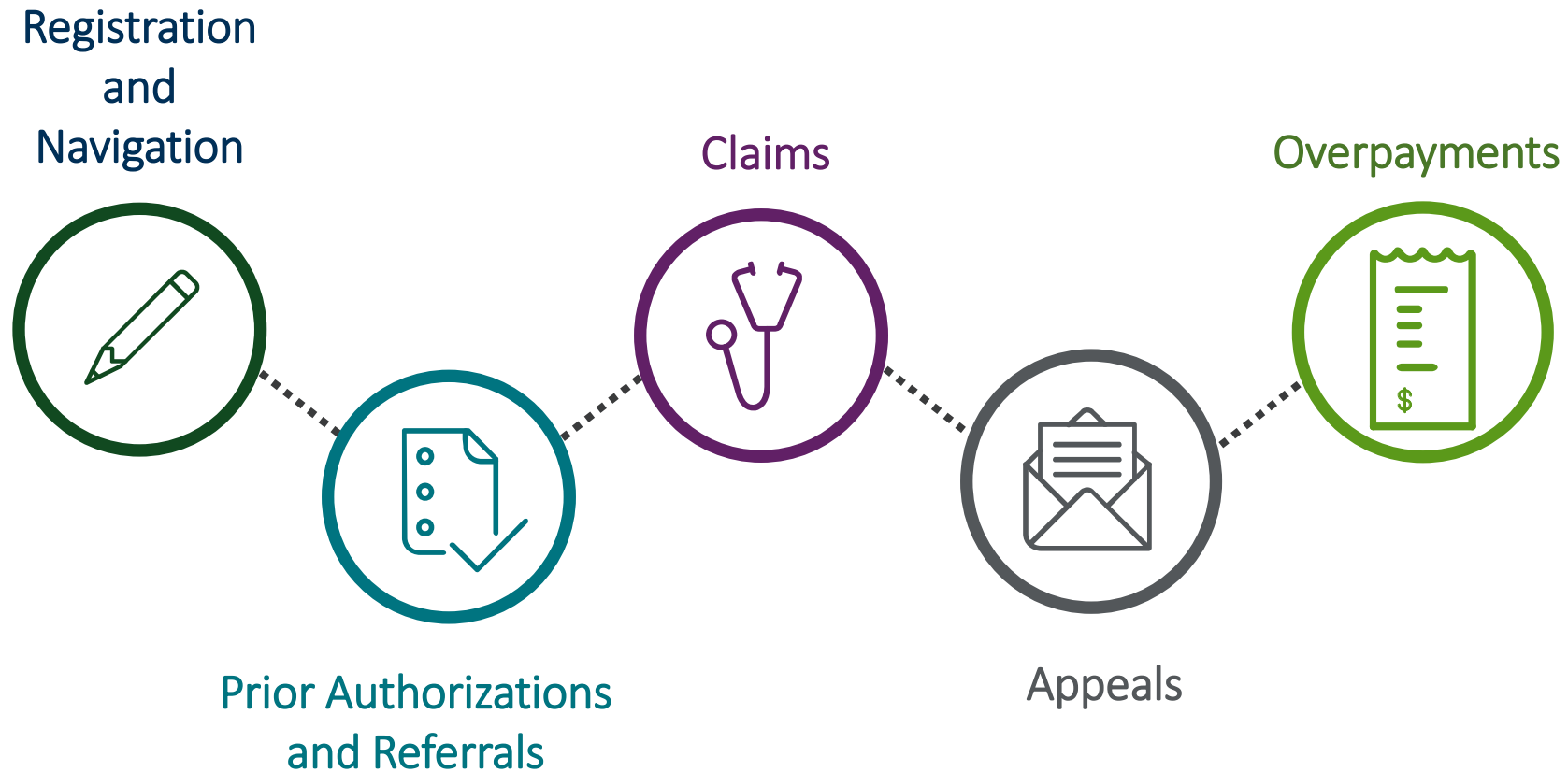
Availity Essentials is Humana Healthy Horizons' electronic data interchange (EDI) clearinghouse and our preferred multi-payer portal for healthcare providers.

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 Legacy Provider Identifier (LPI)/Indiana Medicaid Provider ID should be used when submitting clean claims as well.

**For a step-by-step guide on getting registered in Availity:
[Register your provider organization \(availity.com\)](https://www.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**



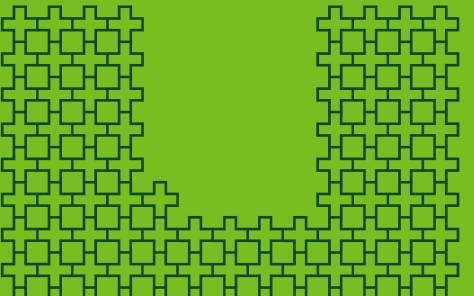
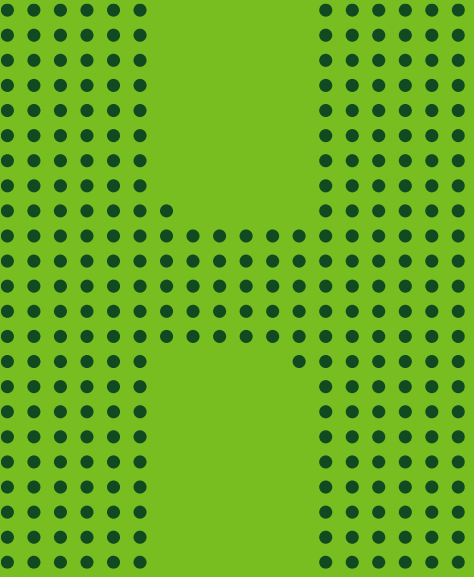
Working with Humana Healthy Horizons Online

[Humana.com/ProviderSelfService](https://www.humana.com/ProviderSelfService)



Humana Provider Services Line

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



Claim Recoupments/Overpayments

Humana Claims Recoupments/Overpayments

The **Claims Research and Resolution team** does **not** handle claims related to:

- Overpayments and claims already identified for recoupment

For assistance with these issues, contact the Provider Payment Integrity (PPI) Department or manage requests through Availity.

- Go to [Availity Essentials](#)
 - Select Claims & Payments
 - Select Dispute Overpayment
 - Within the Dispute Overpayment window, select a dispute (inquiry) type and enter a description of the dispute (inquiry). You must provide a description clearly explaining what is being disputed and why
- If you do not see this option:
 - Contact your organization's Availity Essentials administrator
 - Request access to Claim Status
- You may also contact the PPI Department at 800-438-7885 (TTY: 711) for a first-level review
 - Hours: Monday–Friday, 8 a.m.–8 p.m. ET
 - Confirmation will be provided within 7 business days; review may take up to 45 business days
- If you already have a PPI reference number:
- Email HelpPPI@Humana.com for a **second-level review**

Important: Do **not** send **initial requests** to HelpPPI@Humana.com

Humana Recoupments

Reasons for a recoupment; including but not limited to:

- Paid too much on a claim
- Paid for services not Indiana Health Coverage Program (IHCP) certified to render
 - OMPP will not issue a retroactive date for provider certification
- Paid for services provider isn't contracted to render
- Paid for more services than authorized
- Place of service for assisted living not listed
- 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)
- Retroactive eligibility and enrollments for the member

Recoupment Letter

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

Recoupment Letter

Humana.

<Insert return address>

<Date of letter>

<Recipient name>

<Recipient address>

<Recipient address continued>

<City, state ZIP code>

RE: Refund request — see enclosed chart

Dear <Recipient name>:

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 some claims were paid incorrectly. As part of a recent review, we determined the claims referenced on the enclosed chart were overpaid by \$<overpayment amount>. The reasons for the overpayments are listed on the 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 you do not agree with our findings, please follow the guidance found in the Special Messages section below.

If you 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.

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.

Sincerely,

The Humana Provider Payment Integrity Department

Enclosure: Special Messages, Overpayment chart

Special Messages

Medicare and Commercial claims

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 get started with Availity Essentials, please visit Humana.com/ProviderSelfService.

Medicaid claims (excluding Kentucky)

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 get started with Availity Essentials, please visit Humana.com/ProviderSelfService.

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.

Kentucky Medicaid claims

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

If you do not agree with these findings, you have the right to appeal. Appeals must be received within 30 calendar days from date of this notice. To submit an appeal, please detail your organization's desire to appeal and include all supporting documentation for consideration. You may submit via:

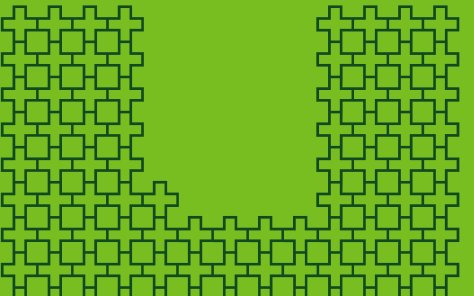
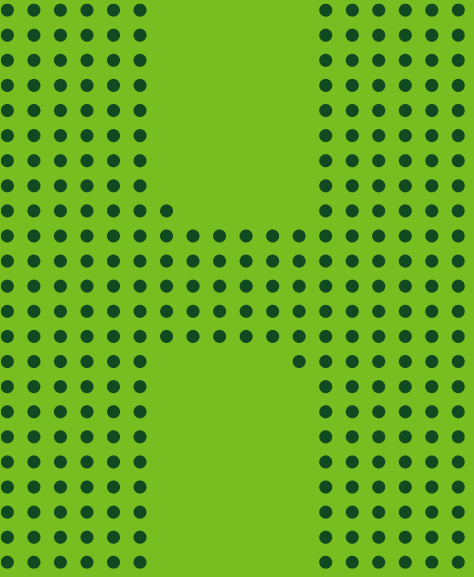
- Fax: **800-949-2961**
- Mail: Humana Healthy Horizons® in Kentucky
Grievances and Appeals department
P.O. Box 14546
Lexington, KY 40512-4546
- Online: Visit Availity Essentials™ at www.availity.com.
○ Go to Claims & Payments

If you have medical records you would like to submit or want to manage Humana overpayments electronically, you can do so at Availity Essentials. You can find the application on the portal under Claims & Payments. To get started with Availity Essentials, please visit Humana.com/ProviderSelfService. If you cannot upload the record(s), you can submit via:

- Fax: **866-305-6655**
- Mail: Humana Medical Records Management
P.O. Box 14465
Lexington, KY 40512-4465

Recoupment Letter Continued

PPI Overpayment Chart: Provider Review										Created <insert date>	
Humana internal provider ID number: <Insert Provider ID>										L1 Action From <insert date>	
Provider tax ID: <Insert Provider Tax ID>										Control Number <insert number>	
Provider Name: <Insert Provider Name>											
	SUF	REL	Claim number	Date of service	Overpaid amount	Recovery item number	Reason	Source	LOB	MKT	PLT CD
Patient:											
Medicaid ID:											
Member Date of Birth:											
Patient Acct. Number:											
Payment Type:											
Check Date:											
Check Number:											
Original Paid Amount:											
Legal Entity:											
Group Number:											
Coverage Type:											
Anticipated Remit Deduct Date:											
Note:											
Overpayment Reason(s): <insert reason>											
Provider Total										\$<insert total> Count <insert count>	



Claims Overview

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 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](https://www.ama-assn.org/practice-management/cpt).
- Healthcare Common Procedure Coding System (HCPCS), available at [CMS.gov/medicare](https://www.cms.gov/medicare).
- National Drug Codes, available at [FDA.gov](https://www.fda.gov).

Humana Claims CPT/HCPC Codes

HIPAA-compliant, CPT, HCPCS, and modifiers when modifiers are applicable

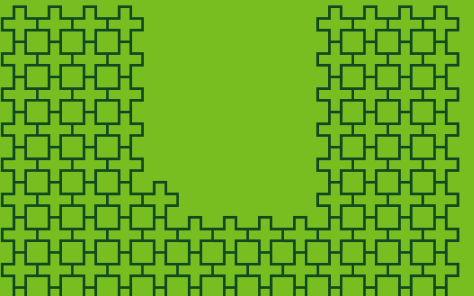
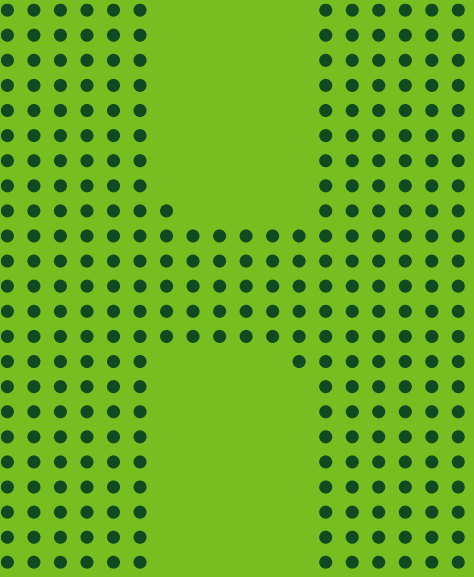
Please note: Humana Healthy Horizons also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reducing administrative burdens on providers and health plan organizations. Local or proprietary codes are no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

CMS 1500 Highlights

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 05/12

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ OTHER ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX ☐ M ☐ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) QUAL.

15. OTHER DATE (MM/DD/YY) QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM/DD/YY) FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY) FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))

22. RE submission CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIES (Specify Unusual Circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. \$ CHARGES G. DATE OF UNIT H. DATE OF UNIT I. \$ CHARGES J. \$ CHARGES K. \$ CHARGES L. \$ CHARGES

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. Paid by NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) ON CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER NPI & PH #

SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMB-0928-1197 FORM 1500 (02-12)

Member
Name

Referring
Provider

Dates of
Service

Tax ID

Rendering
Provider
ID

UB-04 Highlights

Provider Name
and Address

Occurrence
Codes

Revenue
Codes

Patient Control
ID

Type of Bill

Value Codes

HCPC/Rate/DOS/Units

NPI

Provider
Information

1		2		3a PAT CONTL 4 b MED REC 4		4 TYPE OF BILL	
5 FEDI TAX NO				6 STATEMENT COVERS PERIOD FROM THROUGH			
8 PATIENT NAME a				9 PATIENT ADDRESS a			
10 BIRTHDATE				11 SEX			
12 DATE				13 ADMISSION 13 HR 14 TYPE 15 SRC			
16 DHR				17 STAT			
18				19			
20				21			
22				23			
24				25			
26				27			
28				29 ACCT STATE			
30				31 OCCURRENCE CODE			
32 OCCURRENCE DATE				33 OCCURRENCE CODE			
34 OCCURRENCE DATE				35 OCCURRENCE CODE			
36 CODE				37 OCCURRENCE SPAN FROM THROUGH			
38 CODE				39 OCCURRENCE SPAN FROM THROUGH			
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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 adjudicated healthcare claim that includes changes or updates to the original information in order to achieve a different adjudication, payment, or outcome. Corrected claims are typically submitted to address errors, omissions, or inaccuracies that caused the original claim to be denied, delayed, or paid inaccurately.

A rejected claim is a claim that has not accepted for processing because it contains missing, invalid, or incomplete information. It must be corrected and resubmitted before adjudication can occur. A rejected claim will not be assigned a Humana PathWays claim number.

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 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

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 review and update their assessment form with any services missing. Providers must be certified with the state to perform services selected on their assessment form.
- **338** – Multiple months cannot be billed on one claim. Denies when multiple months are billed on a single claim. Providers must bill each month separately for members with a waiver or liability.
- **87P** – Appropriate modifier not billed on the claim.

Claims Common Denials 2

Common denials identified by the Claims Research and Resolution team:

- **86E** – Claim lines not verified by EVV Vendor Sandata.
 - Verify that all visits are entered in Sandata before submitting the claim to Humana. If the visit is not in Sandata at the time of submission, the claim will automatically deny for no visit found..
 - Verify that the number of units entered in Sandata matches the number of units billed on the claim before submitting to Humana. If the claim is submitted with more units than what is recorded in Sandata, the claim will deny for units not matching.
 - Validate you are billing HCBS claims with a waiver billing profile. For example, if HCBS services are billed under a medical billing profile that uses an NPI, the system will not locate the visit in Sandata, even if the visit was entered before the claim was submitted. This happens because the system searches using the Medicaid ID submitted on the claim. If the medical Medicaid ID is used instead of the waiver Medicaid ID, the visit will not match and the claim will deny.
- **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.

Claims Common Denials 3

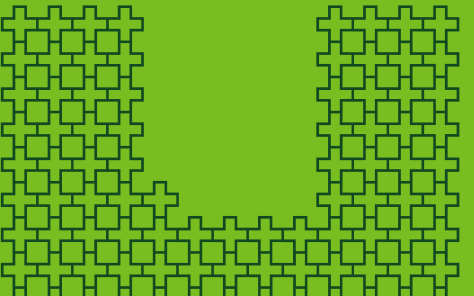
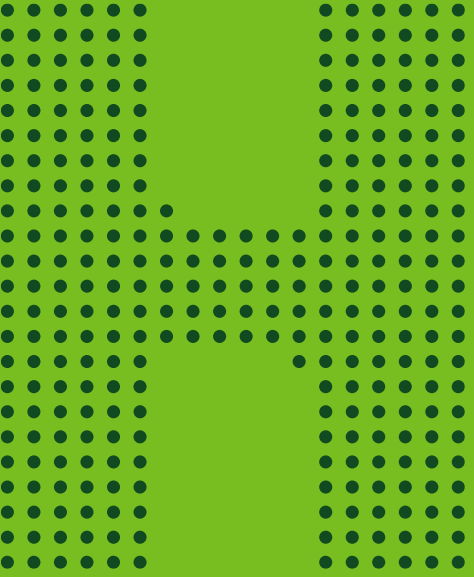
Common denials identified by the Claims Research and Resolution team:

- **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 (for non-HCBS claims). The claim will deny if the ZIP+4 submitted on the claim does not exactly match the ZIP+4 on the provider's W-9 from IHCP enrollment.
The system verifies the Billing NPI, Billing Taxonomy, and the Billing ZIP+4.

Claims Common Denials 4

Common denials identified by the Claims Research and Resolution team:

- **888** – (For Non HCBS claims) The rendering provider must be linked to the pay to provider's group enrollment and service location to receive reimbursement. A rendering provider may only bill for services performed at a service location where they are affiliated with the enrolled group provider. If the rendering provider is not linked correctly, the claim will deny. Providers can add or remove rendering provider affiliations in the Provider Maintenance section of IHCP. For additional guidance, refer to [Claim Submission and Processing](#).
- **53Y** – (For Non HCBS claims) Taxonomy for the billing provider NPI was incorrect. Providers Taxonomy may be needed to establish a one-to-one NPI/LPI match if the provider has multiple locations.
- **05D** – Expense not covered –Timely Filing Claims must be received within 90 days from the date of service. Corrected Claims on denied claims: If the initial claim is denied for any reason, the corrected claim must also be submitted within the original 90-day period from the date of service. Corrected Claims on paid Claims: If the provider is submitting a corrected claim for a previously paid claim, it must be received within 60 days from the date of payment.



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

[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

[CMS Claims Processing Manual](#)

- Ensuring accuracy and completeness in initial claim submissions
- Staying up to date with payer requirements
- Reduce rework and speed up reimbursement

Additional Resources continued...

[CMS Manual System - Pub. 100-04 Medicare Claims Processing](#)

- To facilitate accurate processing and payment of healthcare claims that could otherwise result in claim denials, underpayments, or overpayments

[Claim Submission and Processing](#)

- IHCP Provider Reference Module



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

Humana
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Thank you

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