HMA provider FAQs

GENERAL BACKGROUND

Q: What is HMA?

A: HMA is a TPA product being offered to self-funded employer groups (groups who pay out claims themselves) with 100 or more employees, in strategic collaboration with Healthcare Management Administrators, Inc. (HMA).

Q: Who is Healthcare Management Administrators, Inc.?

A: Healthcare Management Administrators, Inc. (HMA) is a leading third-party administrator (TPA) of benefits for self-funded health plans, expertly serving employers for nearly 40 years. Learn more about HMA on their website.

Q: What is a TPA product?

A: A third-party administrator (TPA) is a company that provides operational services, such as prior authorizations, claims processing, member support, etc. This TPA product will be administered by HMA, while the member maintains access to the Priority Health network. It is **not** a leased network.

Q: Why is Priority Health launching a TPA product?

A: As the market and health care evolve, we recognize that employers are looking for more options when it comes to self-funded products (plans that are underwritten by the employer). These employers want flexible, custom solutions designed specifically for their unique needs. There are many advantages to a TPA product like HMA, including:

- **Flexibility** for employer groups to partner with a best-in-class TPA to set up their plan to fit the specific needs of the group's population
- **Control** over all coverage decisions
- **Access** to Priority Health's PPO network and discounts while maintaining the advantages above

Q: Does this TPA product benefit providers?

A: This product supports our ongoing effort to bring more competition to Michigan, giving us more ability to sell to self-funded employer groups while giving providers more business at our rates. This is good for health systems and great for the marketplace overall.

Q: How does this impact my reimbursement?

A: This product will use our broad network PPO rates within our existing provider agreements, so your reimbursement shouldn't be impacted.

**Note that HMA has its own payment integrity processes.*

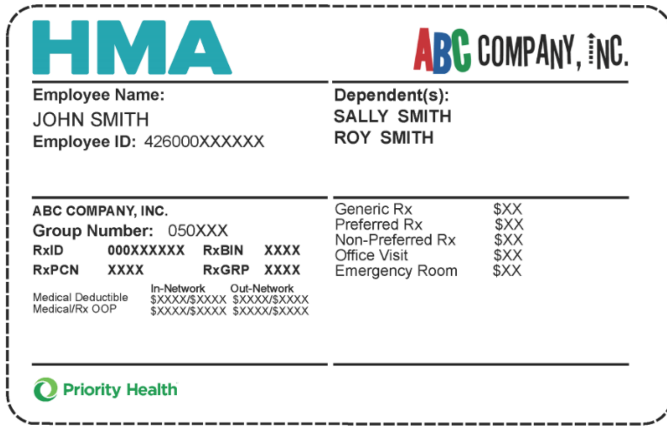
SEEING HMA PLAN MEMBERS

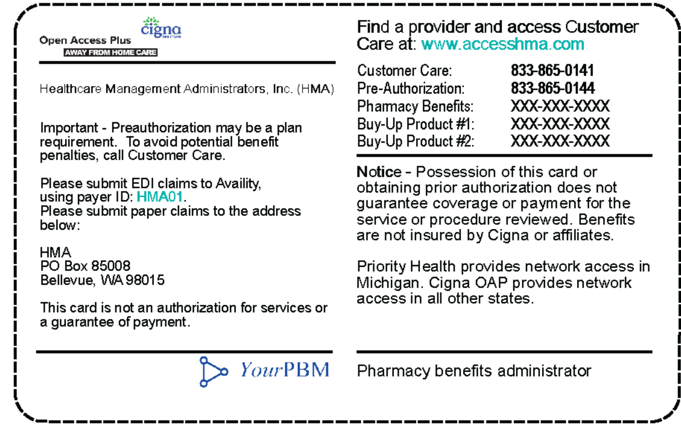
Q: How many members will there be on Priority Health HMA plans?

A: We anticipate that this will be a niche product with slow growth in the market. We're anticipating only a few thousand members the first year, primarily in the West and Southeast regions of Michigan.

Q: What do the member ID cards look like?

A: Member ID cards will have HMA's logo in the upper left, the employer group's logo in the upper right, the logo for Priority Health in the bottom left and the logo for Cigna on the back of the card. These last logos are a reminder that HMA members use Priority Health's PPO network in Michigan and Cigna's OAP network outside of Michigan. See the sample card images below.





Remember: If you see this card, and you participate with Priority Health's PPO network, this member is in-network for you.*

**Bronson providers are not participating in the HMA network.*

Q: Do I need to get credentialed with HMA?

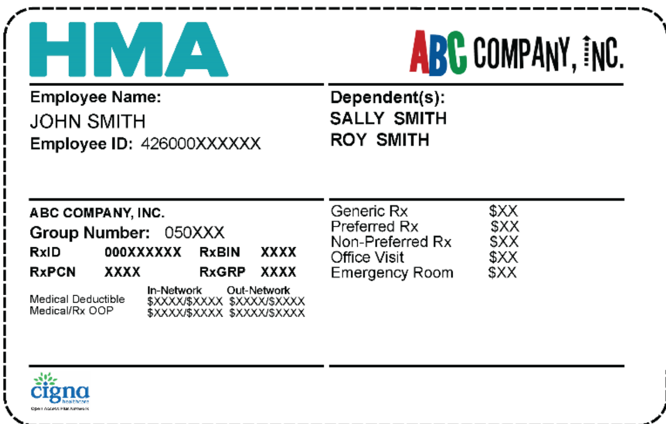
A: No. If you're a credentialed provider with Priority Health, you're all set to serve HMA plan members.

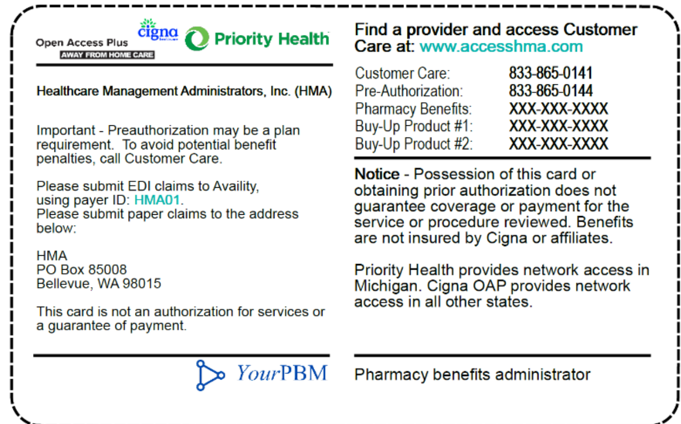
Q: Are HMA plan members covered for care received outside of Michigan?

A: Yes, as long as the out-of-state provider is part of Cigna's Open Access Plus (OAP) network, the member is eligible for coverage. Simply follow card instructions and submit claims to HMA. See our provider manual for more information. All terms of the alliance that apply to Priority Health members also apply to HMA plan members.

Q: Do HMA plan members who live outside of Michigan have different member ID cards?

A: Yes, HMA plan members who live outside Michigan will have a member ID card that has the Cigna logo on the front and the Priority Health logo on the back, the reverse of what it is for members who live in Michigan. See below for sample images.





Q: What are the tools I'll use to work with HMA members?

A: See the tiles below for guidance on what tool to use for each function. See below in the questionnaire for details on each tool.

Provider portal

- ✓ Viewing patient eligibility
- ✓ Viewing Explanations of Payment (remittance advice) on closed claims
- ✓ Reviewing plan summaries
- ✓ Submitting prior authorization requests
- ✓ Updating provider information
- ✓ Asking questions (Express Requests)

Phone support*

- ✓ Member eligibility and benefits information
- ✓ Claims status
- ✓ Prior authorizations
- ✓ General questions and support

CALL 833.865.0141

*Phone support includes live agent assistance on Mon.–Fri., 8:00AM–9:00PM Eastern.

Availity

- ✓ Submitting claims*
- ✓ Tracking claims status
- ✓ Member benefit checks
- ✓ Member accumulators (deductible, out-of-pocket)
- ✓ Payment information

*Use payer ID **HMA01**. You can also fax claims to **866.458.5488** or mail them to: HMA, Attn: Claims Department, P.O. Box 85008, Bellevue, WA 98015.

DIGITAL TOOLS

Q: Is there a provider portal for HMA?

A: Yes, register for the HMA provider portal by clicking on the Not Registered link and go through the steps to create an account. You can also access the portal at priorityhealth.com/provider/HMAproviderportal.

Q: What is the provider portal used for?

A: The provider portal is used for:

- Viewing patient eligibility
- Viewing Explanations of Payment (remittance advice) on closed claims
- Reviewing plan summaries
- Submitting prior authorization requests
- Updating provider information
- Asking questions (Express Requests)

For details about using the portal for each of these activities, see our HMA provider portal training guide.

Q: What is the turnaround time for inquiries (Express Requests)?

A: The response time is a maximum of 15 days. The exact amount of time depends on the complexity of the question. Over half of Express Requests are answered same-day.

Q: Will HMA plan member information also show up in prism's Member Inquiry tool?

A: No, enrollment and membership are managed by HMA, so providers will need to access the HMA portal for all member information.

Q: Does HMA have a provider support line?

A: Yes, call **833.865.0141** for access to a self-serve interactive voice response (IVR) system. You can use the IVR system for:

- Member eligibility and benefits information
- Claims status
- Prior authorizations

Make sure when you call in that you have your NPI and your Tax ID number, as well as the member's ID number and birth date. You should also have your fax number ready if you want the information you're seeking faxed to you afterward.

Q: Can I speak to a live representative at HMA's support line?

A: Yes, the IVR prompts will give you the option to speak to a representative at the appropriate point in the process. Live representatives are available Monday–Friday, 8:00AM–9:00PM Eastern Time.

Q: Does HMA's support line give you a reference number for your query?

A: Yes, you will be given a reference number for both the self-serve IVR system and a live call so you can return to an open case more quickly in case you need to call back again.

Q: What type of EDI transactions does HMA accept?

A: HMA accepts:

- 270/271 – Eligibility inquiry and response
- 276/277 – Claim status and response
- 834 – Enrollment
- 835 – Payment and remittance advice
- 837 – Claims and encounters (P and I)

SUBMITTING CLAIMS

Q: How should claims be submitted?

A: Claims should be submitted to HMA, per member ID card instructions. HMA accepts electronic claims through Availity using payer ID **HMA01**. You can also submit claims via fax at **866.458.5488** or via mail to:

HMA
Attn: Claims Department
P.O. Box 85008
Bellevue, WA 98015

Q: What coding guidelines should I follow?

A: Please follow ICD-10 coding guidelines. Claims received with an ICD-9 code will be rejected with a notice to re-bill using ICD-10.

Q: Could I get more information about using Availity?

A: If you haven't already, sign up for Availity at availity.com. Use the "Help & Training" button in the upper-right corner of the screen at any time for guides to using Availity.

Q: Can I see a member's accumulator totals?

A: Yes, you can see accumulator totals in Availity or by calling HMA's support line at **833.865.0141**.

Q: How do I check the status of a claim?

A: You can view all claims, including Explanations of Payment (remittance advice), on the provider portal. You can also track claims on Availity or call in to the support line at **833.865.0141**.

Q: What is the claim denial rate?

A: HMA's claim denial rate is around 5%. If information on a claim is missing, HMA will send a letter to the provider requesting additional information and will "hold" the claim briefly to give the provider time to respond. Once HMA has the claim in house for a total of 45 days without response, the claim will be denied, and the provider will need to resubmit or appeal for further consideration.

Q: How will I get paid?

A: Providers will receive paper checks until they complete an enrollment form for Electronic Funds Transfer (EFT) with ECHO, HMA's payment partner.

Q: How do I sign up to receive electronic remittance advice (ERA)?

A: Sign up for ERA using the same enrollment form as you use to enroll in EFT with ECHO.

Q: How do I appeal claim denials?

A: The preferred means of appealing a denied claim is for the member to do so via the member portal. However, providers may also appeal denied claims by writing to HMA, including the following information:

- A detailed description of the disputed issue(s)
- The basis for disagreement with the decision
- All evidence and clinical documentation supporting your position

HMA also needs a completed Appeal Submission Form signed by the member in order for the provider to appeal on behalf of the member. Without this completed and signed form, appeals will be rejected and an Appeal Submission Form will be mailed out.

You may also download and print the Appeal Submission Form and send it in via fax to **855.462.8875** or via mail to:

HMA
Attn: Appeals Department
P.O. Box 85016
Bellevue, WA 98015

Note that this information is always included on claim denial documentation.

Q: How will I hear about appeal decisions?

A: If the appeal is denied, the provider will be sent a letter explaining the decision. If it is accepted, the claim will be adjusted and the provider will be sent an EOP showing the details of the claim payment.

AUTHORIZATIONS

Q: How do I determine if a service needs prior authorization?

A: Please call HMA's support line at **833.865.0141** and provide the service code when prompted by the IVR system. HMA will let you know if the service requires prior authorization.

Availity also lists a member's plan information, including which services need prior authorization. However, this information on Availity is not searchable by CPT code.

Q: How do I submit a prior authorization?

A: You have two options to submit a prior authorization. You can either submit the Authorization Request form on the Provider Forms & Info page of the provider portal, or you can call the provider support line at **833.865.0141** and follow the prompts to complete a prior authorization.

Q: What is the turnaround time for authorization requests?

A: The response time for both is a maximum of 15 days. The exact amount of time depends on the complexity of the authorization request. Over half of authorization requests are answered same-day.

Q: How will I hear about an authorization decision?

A: You will receive a letter from HMA with the authorization decision. If the authorization is denied, you'll also receive a phone call.

Note that when you submit the authorization form on the portal, you'll receive a reference number, which you can use to check on the status of the authorization at any time.

Q: How do I appeal authorization denials?

A: Please write to HMA, including the following information:

- A detailed description of the disputed issue(s)
- The basis for disagreement with the decision
- All evidence and clinical documentation supporting your position

HMA also needs a completed Appeal Submission Form signed by the member in order for the provider to appeal on behalf of the member. Without this completed and signed form, appeals will be rejected and an Appeal Submission Form will be mailed out.

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MEDICAL POLICY AND CASE REVIEW

Q: What medical policy does HMA use?

A: HMA uses Cigna's medical policies as primary. If Cigna lacks relevant policy, HMA will turn to MCG criteria. MCG provides evidence-based guidelines for medical necessity (www.mcg.com).

Q: What medical policies are used for cancer cases?

A: When Cigna does not offer a suitable policy, HMA will rely on The National Comprehensive Cancer Network (NCCN) (www.nccn.org).

Q: How does HMA carry out independent physician review?

A: When necessary, HMA will engage AllMed Healthcare Management (www.allmedmd.com).

INCENTIVE PROGRAMS

Q: Are HMA plan members part of the PCP Incentive Program (PIP)?

A: No, HMA plan members aren't included in PIP measurements, similar to how Cigna members using the Priority Health network aren't included in PIP.