Humana's YourPractice

Correctly Code Authorizations Using ICD-10

Humana is now accepting ICD-10 coded authorizations and referrals with dates of service on or after the Oct. 1, 2015, the official ICD-10 implementation date. Humana will continue to accept authorizations and referrals that use ICD-9 codes for a year after the implementation date.

The ICD-10 implementation date is October 1, 2015

If an authorization or referral is submitted to Humana before Oct. 1, 2015, regardless of date of service, Humana will accept ICD-9 codes. Authorizations and referrals submitted from July 1, 2015, to Sept. 30, 2016, can have either ICD-9 or ICD-10 codes on them, but not both.

To help ease the transition, Humana will accept ICD-9-coded authorizations and referrals through Sept. 30, 2016. After that, any authorization, referral or updates to existing authorizations and referrals must use ICD-10 codes.

For claims themselves, Humana is following the Centers for Medicare & Medicaid Services (CMS) ICD-10 claim coding guidelines. Based on these guidelines, the date of discharge will determine whether inpatient claims should contain ICD-9 or ICD-10 codes. For dates of discharge of Oct. 1, 2015, or after, only ICD-10 codes may be used.

For outpatient claims, dates of service determine which code set to use. For a service that spans the implementation date, the claim should be split so that ICD-9 codes are all on one claim with dates of service through Sept. 30, 2015. ICD-10 codes should be placed on a separate claim with dates of Oct. 1, 2015, and after.

Detailed instructions from CMS on ICD-10 claim coding rules that span the implementation date are available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf

ICD-10 stands for the International Classification of Diseases, 10th Edition. ICD codes are medical codes that provide a detailed representation of a patient's conditions or diagnosis. ICD-10-CM (clinical modification) codes are diagnosis codes, and ICD-10-PCS (procedure coding system) are for hospital inpatient procedures.

An entity covered by the Health Insurance Portability and Accountability Act (HIPAA) must be able to successfully conduct health care transactions using ICD-10 diagnosis and procedure codes on or after the Centers for Medicare & Medicaid Services (CMS) implementation date of Oct. 1, 2015.

For questions related to ICD-10, contact Humana via the following email addresses:

- Claim delegates who submit delegated encounters — IPAICD10Inquiries@humana.com
- Physicians contracted with Humana — ICD10Physician@humana.com
- Facilities — ICD10Inquiries@humana.com

Humana Partnerships Support Physicians in Their Transition to Value-based Care

Dear physicians and health care providers:

I've spoken with many physicians who instinctively know the change from fee-for-service to value-based reimbursement is the future of health care and good for their practice, but are dealing with systems that make it hard to transition and also feel disadvantaged from an incentive standpoint.

We also found this to be true among health care executives when we recently sponsored a survey of 146 senior financial executives. The survey (http://www.hfma.org/value-basedpaymentreadinesssurvey), conducted by Healthcare Financial Management Association (HFMA), shows executives ranked their ability to understand data on their patient population as a key enabler of their success in value-based reimbursement arrangements.

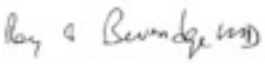
Organizations like Humana can facilitate a physician's ability to effectively manage populations of patients in a cost-effective manner while also helping to improve quality care. For instance, Humana shares valuable information with primary care physicians (PCPs), such as whether a patient has filled a prescription, visited the ER or seen a specialist without discussing it with the PCP first.

One relationship that I think does an especially good job of showcasing ways Humana and physicians are working together is our partnership with Iora Health. This partnership focuses on care coordination, diabetes care and treatment, breast cancer screenings, colorectal cancer screenings and monitoring for high-risk medications.

I invite you to listen to Rushika Fernandopulle, M.D., M.P.P., CEO and cofounder of Iora Health, describe our partnership in this video (http://media.humana.com/videos/Population_Health/MP4/Population_Health.mp4).

Humana has deep and broad experience in population health. I encourage you to reach out to us to learn how we can help you transition to value-based care.

Sincerely,



Roy Beveridge, M.D.
Senior Vice President and Chief Medical Officer

New Initiative Focuses on Preventive Care for "On-Exchange" Membership

Dear physicians and office staff:

Our Provider Organized Delivery System (PODS) team is on a mission to improve Humana members' quality of life. Recently, we began a new initiative to expand PODS to our San Antonio "on-exchange" membership.

These members have an HMOx benefit plan, which is similar to a traditional HMO plan, but also includes additional benefits required by the Affordable Care Act. This means most preventive care is covered at 100 percent. Since many of these patients may be new to their physicians and may not understand the benefits of preventive care, it is important that Humana and physicians work together to engage them.

This new initiative matches physicians with a PODS point of contact who provides the following information:

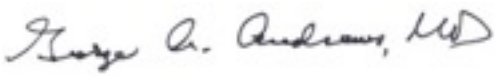
- An updated list of patients who are Humana "on-exchange" members.
- A current listing of in-network specialists to whom these patients can be referred for treatment.
- Information about pharmacy financial assistance programs for patients who are unable to afford their prescriptions.
- A list of covered preventive services for these patients.

To help Humana learn what health challenges these patients face, physicians provide the following health information for patients with Humana HMOx coverage:

- Body mass index (BMI)
- HbA1c
- Nephropathy
- Breast cancer detection

We hope to expand this initiative to all markets soon. Together, we can work to break down barriers to care and improve members' quality of life.

Sincerely,



George A. Andrews, M.D., M.B.A., F.A.C.P., F.A.C.C., F.C.C.P.

Value-based Care Improves Health Outcomes and Costs

Humana has extensive experience working with physicians in accountable care relationships that encourage moving from a fee-for-service model in which physicians are paid "per visit" to a model that rewards patient outcomes.

These relationships focus on giving primary care physicians (PCPs) population health solutions they need to become successful in managing patient's health. Humana's programs not only offer support for physician practices as they move into value-based relationships, but they also can help improve the patient experience.

Nationally, as Humana moves toward value-based care, the improvements in quality, utilization and costs are evident.

Humana compared quality, outcomes and costs for approximately one million Humana Medicare Advantage (MA) members who were treated by health care providers in Humana's accountable care continuum programs versus members who were treated in traditional, fee-for-service and Original Medicare settings. The results show that Humana's accountable care continuum has had a positive, measurable impact on the quality of care, such as:

- **Better quality:** Humana's accountable care, or pay-for-value relationships, experienced a higher Healthcare Effectiveness Data and Information Set (HEDIS) Star score average of 4.25, as compared to health care providers outside of accountable care settings who average a HEDIS Star score average of 3.65.

- **Improved population health:** Humana Medicare Advantage (MA) members in accountable care relationships experienced 7 percent fewer emergency room visits per thousand and 4 percent fewer inpatient admittances per 1,000 than those in traditional, fee-for-service settings. These members also experienced improvements in clinical management and screening compliance. For example, screening compliance for Humana MA members with diabetes increased by 7 percent for each of the following: cholesterol control, eye exams and blood sugar. Cholesterol screening for cardiovascular care increased by 5 percent.

- **Lower costs:** Humana experienced a 19 percent cost improvement in total in 2013 for members who were treated in an accountable care setting versus members who were treated by health care providers in Original Medicare settings.

Value-based reimbursement

Value-based reimbursement is the foundation on which Humana developed its accountable care continuum (202 Kb, http://apps.humana.com/marketing/documents.asp?file=2584036).

Humana offers financial rewards for improvements in outcomes, quality and cost through Humana's Provider Quality Rewards Program (https://www.humana.com/provider/support/accountable-care/summary). This continuum of programs supports PCPs as they develop their population health management capabilities and focus.

Population health solutions

Humana's population health solutions focus on four areas: care management, clinical integration, financial management and patient engagement. Clinical care integration and care management are two especially important areas of focus, and Humana offers tools that support PCPs as they manage patients with chronic care conditions. These tools include predictive analytics, identification of real-time gaps in care, clinical alerts and health information exchanges.

The benefits for patients

Humana's integrated approach to population health has meaningful impact on quality and costs.

Care management extends beyond the PCP's office. Humana's multidisciplinary teams, made up of health coaches, nurses, care managers and social workers, motivate members to make better lifestyle choices, including healthy, chronically ill and underserved individuals. Members of the teams call and/or visit members. Community health educators also work to connect members with the community and social services they need.

This type of outreach is making a difference in members' quality of life and health care costs. For example, the Humana Chronic Care Program (HCCP) identifies members for chronic care and post-acute transitions programs. This may help people stay at home longer and reduce hospital admissions and readmissions. Physicians can watch a video that includes actual members describing the impact these programs have on their health and their care satisfaction by visiting https://www.humana.com/provider/support/accountable-care/.

For more information about the physician and patient benefits of accountable care relationships, physicians can contact their Humana representative or send an email to providerengagement@humana.com.

Humana Member Summary Provides Opportunities for Improving Patient Outcomes

Humana designed the Humana Member Summary to help identify additional actionable care opportunities that may improve clinical outcomes. Humana Member Summary provides a standardized, 365-day snapshot of a member's medical history. It is no more than three pages long and integrates easily into a physician's practice workflow and electronic medical records (EMRs). The Humana Member Summary is available for both Medicare and commercial Humana members.

How to access Humana Member Summary

Physicians can access Humana Member Summary through the secure provider website at **Humana.com** (http://www.humana.com/) or Availity.com (http://availity.com/) (registration required). Humana Member Summary can also be accessed through select EMRs.

When to use Humana Member Summary

Physicians can use Humana Member Summary to identify gaps in care and to initiate discussions with the member at the point of service. The tool provides easy access to care alerts, Healthcare Effectiveness Data and Information Set (HEDIS®) gaps, member prescriptions, past diagnoses and more.

Information for a Humana Medicare or commercial member is organized into the following sections of the Humana Member Summary:

- Member demographic data
- Patient quality
- Health condition history
- Prescription history
- Lab results
- Patient admission/ER visits

To get more information about Humana Member Summary, physicians can call provider relations at 1-800-626-2741, Monday through Friday, 8 a.m. to 5 p.m. Central time, contact their market representative or email questions to membersummary@humana.com.

Education Key to Successful Sleep Apnea Treatment

According to the National Heart, Lung, and Blood Institute, untreated obstructive sleep apnea (OSA) increases the risk of high blood pressure, heart attack, stroke, obesity and diabetes. Physicians most commonly treat moderate-to-severe OSA with a positive airway pressure (PAP) device, which delivers a stream of air through a mask or nasal pillow to keep the airway passages open during sleep. Even though use of a PAP machine can help ease the

symptoms of sleep apnea (e.g., snoring, nonrestful sleep, daytime drowsiness, low energy, etc.) and improve the patient's overall quality of life, some patients may have issues with treatment that result in nonadherence.

Humana offers the following tips for physicians to encourage adherence for patients with OSA:

- **Talk to the patient about common side effects.** Better educated patients who know what to expect during treatment are more likely to remain adherent over the long term. Most people will notice some side effects from the PAP machine at some point during treatment. The most common side effects are mask- or pressure-related issues, such as claustrophobia, nasal congestion or runny nose. Serious side effects are uncommon.

- **Encourage the patient to ease into treatment and to stick with it through the beginning of treatment.** Most people need a few days or even up to a few weeks to get used to the PAP mask and the feel of the air pressure created by the PAP unit.

- **Consider an alternative PAP device for patients having difficulty.** If the patient is on a continuous positive airway pressure (CPAP) device, try an autotitrating positive airway pressure (APAP) device or oral appliance.

- **Offer the following tips to deal with the most common issues patients have with PAP therapy:**

    - **Mask discomfort:** Many people find the mask uncomfortable at first. Suggest having the fit adjusted or trying a different type of mask.

    - **Forced-air discomfort:** If using a CPAP, determine whether the patient's air pressure could be adjusted. Many people do well if they start at a lower pressure and gradually increase it.

    - **Dry mouth or runny nose:** Most PAP machines can humidify the air to fix these problems. Suggest patients talk to their durable medical equipment (DME) provider if they need assistance adjusting the humidity.

    - **Claustrophobia:** Suggest patients wear the PAP mask for short periods of time during the day when they are awake and busy with other activities, such as watching television.

For more information about treating OSA, physicians can call Humana at 1-800-448-6262, Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

LifeSynch Renamed "Humana Behavioral Health"

This summer, LifeSynch transitioned to Humana Behavioral Health, continuing LifeSynch's integrated approach to health and well-being.

Patients may approach their physicians and other health care providers with questions about the change. Humana Behavioral Health asks that clinicians remind their Humana-covered patients that only the name has changed.

Why change the name?

LifeSynch has experienced years of successful growth as a wholly owned Humana subsidiary serving millions of members and offering extensive behavioral health products and solutions, including integrated medical-behavioral health and managed behavioral health. This name change simply reinforces the connection with Humana.

How does this change affect health care providers?

The name change has no affect on health care providers' contracts or reimbursement. For more information, visit humanabehavioralhealth.com or call 1-800-890-8288.

Be Aware of Reimbursement Changes on Claims with Modifier 53

Humana wants to make physicians and other health care providers aware of a change in reimbursement of claim line items billed with modifier 53. Humana placed notification about this change on the Claims Processing Edits page (https://www.humana.com/provider/medical-providers/education/claims/processing-edits) of **Humana.com** on March 21, 2015.

According to the American Medical Association (AMA) Coding with Modifiers publication:

A physician may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances or those that threaten the well-being of the patient. The discontinued procedure may be reported by adding modifier 53 to the code. Modifier 53 is used only for professional services.

Resources: AMA Coding with Modifiers Fourth Edition
Medicare Claims Processing Manual, Chapter 12 (Rev. 3096, 10-17-14)
Optum Coding and Reimbursement Educational Series: Understanding Modifiers (2014)

What is changing for charges submitted with modifier 53?

Commercial plans: participating and nonparticipating providers

- A 71 percent reduction will be applied. The claim line will be allowed at 29 percent of the applicable base-allowable amount for the procedure code.

Medicare Advantage plans

- Participating providers – A 71 percent reduction will be applied. The claim line will be allowed at 29 percent of the applicable base-allowable amount for the procedure code.
- Nonparticipating providers – An operative report is required to determine the appropriate reduction based on how much of the procedure is completed.
- Current Procedural Terminology (CPT®) code 45378, Healthcare Common Procedure Coding System (HCPCS) code G0105 and HCPCS code G0121, billed with modifier 53, will be allowed according to the Medicare Physician Fee Schedule Database (MPFSD).

Medicaid plans

- Florida – To align with the Florida Agency for Health Care Administration (AHCA), the Humana Managed Medical Assistance (MMA) program will allow professional services submitted with modifier 53 at 25 percent of the base allowable amount.

- Illinois – To align with the practices of the Illinois Department of Healthcare and Family Services, the Humana Integrated Care Program of Illinois and the Humana Gold Plus Integrated program will not allow a charge submitted with modifier 53. A service should be reported only when completed in its entirety.

Dual Medicare-Medicaid plans

- Virginia – To align with Virginia Department of Medical Assistance Services, Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan will allow a professional service submitted with modifier 53 based upon the percentage of the service actually completed; therefore, an operative report is required.

- Illinois – The Humana Gold Plus Integrated plan will handle claims submitted with modifier 53 accordingly:

    - If a service is covered by Medicare, but not by Medicaid, Medicaid will pay the full amount of deductible and coinsurance up to the Medicare allowable amount.

    - If a service is covered only by Medicaid, Medicaid will pay the Medicaid maximum rate for that service.

The reimbursements listed above for commercial, Medicare, Medicaid and dual Medicare-Medicaid plans may be subject to other applicable adjustments.

Considerations before submitting claims with modifier 53:

- Modifier 53 is inappropriate for evaluation and management (E/M) charges. E/M charges submitted with modifier 53 will not be covered. Physicians and other health care providers are reminded that the member should not be balance-billed for these charges.

- Facility charges billed with modifier 53 will not be covered, as these charges are considered to be inappropriately billed.

- Modifier 53 should be used only when the procedure is discontinued after anesthesia is administered.

- When a laparoscopic or endoscopic procedure is converted to an open procedure, modifier 53 is not appropriate.

For more information about the proper use of modifier 53 and reimbursement of claims, physicians and other health care providers can call 1-800-448-6262, Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

CMS Requires Notification of Hospital Discharge Rights for Medicare Advantage Members

The Centers for Medicare & Medicaid Services (CMS) requires that hospitals deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries, including Medicare Advantage (MA) plan members who are hospital inpatients. Hospitals are required to provide the IM to the MA member upon admission and at least two

days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form. The form and instructions regarding the IM may be found on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

The IM informs hospitalized MA beneficiaries about their hospital discharge appeal rights. MA members who are hospital inpatients have the statutory right to request an "immediate review" by a quality improvement organization (QIO) when Humana, along with the hospital and physician, determines that inpatient care is no longer necessary.

Guidelines for IM notification by telephone

If the hospital staff is unable to personally deliver the IM to the patient or his or her representative, then the hospital staff should telephone the patient or representative to advise him or her of the member's rights as a hospital patient, including the right to appeal a discharge decision.

At a minimum, the notification should include:

- The name and telephone number of a contact at the hospital.
- The beneficiary's planned discharge date and the date when the beneficiary's liability begins.
- The beneficiary's rights as a hospital patient, including the right to appeal a discharge decision.
- How to get a copy of a detailed notice describing why the hospital staff and physician believe the beneficiary is ready to be discharged.
- A description of the steps for filing an appeal.
- When (by what time/date) the appeal must be filed to take advantage of the liability protections.
- To whom to appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires in order to receive the appeal in a timely fashion.

The date that the hospital staff conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.

The hospital is required to:

- Confirm the telephone contact by written notice mailed on that same date.
- Place a dated copy of the notice in the member's medical file and document the telephone contact with either the member or his or her representative on either the notice itself or in a separate entry in the member's file.
- Ensure that the documentation indicates that the staff person told the member or representative the planned discharge date, the date that the beneficiary's financial liability begins, the beneficiary's appeal rights and how and when to initiate an appeal.
- Ensure that the documentation includes the name of the staff person initiating the contact, the name of the member or representative contacted by phone, the date and time of telephone contact and the telephone number called.

When direct phone contact with a member or a member's representative cannot be made, the hospital must:

- Send the notice to the member or representative by certified mail, return receipt requested or via another delivery method that requires signed verification of delivery. The date of signed verification of delivery (or refusal to sign the receipt) is the date received.
- Place a copy of the notice in the member's medical file and document the attempted telephone contact to the member or representative.
- Ensure that the documentation includes:
  - The name of the staff person initiating the contact.
  - The name of the member or member's representative.
  - The date and time of the attempted call.
  - The telephone number called.

Right to appeal a hospital discharge

When members choose to appeal a discharge decision, the hospital or their Medicare health plan must provide them with the Detailed Notice of Discharge (DND). These requirements were published in a final rule, CMS-4105-F: Notification of Hospital Discharge Appeal Rights, which became effective on July 2, 2007.

When the QIO notifies the hospital and Humana of an appeal, Humana will provide the hospital with a DND. The hospital is responsible for delivering the DND to the member or his or her authorized representative on behalf of Humana as soon as possible, but no later than noon local time of the day after the QIO notifies Humana or the hospital of the appeal. The facility must fax a copy of the DND to the QIO and to Humana.

If the member misses the time frame to request an immediate review from the QIO and remains in the hospital, he or she may request an expedited reconsideration (appeal) through Humana's appeals department.

For more information about notification of termination requirements, practitioners may visit the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Completion of 2015 Provider Compliance Training Materials Needed

The Centers for Medicare & Medicaid Services (CMS) mandates that all Humana-contracted entities, including those contracted with Humana subsidiaries, complete compliance requirements related to the following materials:

- Compliance Policy for Contracted Health Care Providers and Business Partners
- Ethics Every Day for Contracted Health Care Providers and Business Partners (Standards of Conduct)
- General Compliance and Fraud, Waste and Abuse (FWA) training
- Special Needs Plans (SNP) training (if the organization has physicians or other practitioners participating in any Humana Medicare HMO network in one of the following states or territories: Alabama, Arkansas, Arizona, California, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Missouri, Mississippi, North Carolina, Nevada, New York, Ohio, Puerto Rico, South Carolina, Tennessee, Texas, Virginia or Washington)

- Medicaid-specific trainings (if the physician's or practitioner's organization is supporting a Humana-Medicaid plan): Humana Orientation Training; Medicaid Provider Training; Health, Safety and Welfare Training; and Cultural Competency Training

Health care providers can complete this information online via Humana's secure compliance website. To access the website, health care providers must be registered on **Humana.com/providers** (http://www.humana.com/providers) or Availity.com (http://availity.com/). Detailed instructions and additional information on completing these requirements, including registration, are available here. While physicians and other practitioners are encouraged to complete the compliance requirements within 30 days of notification, these requirements must be completed no later than Dec. 1, 2015.

Important notes:

- The review and confirmation (via attestation form) of these materials helps meet health care providers' contractual obligation to comply with state and federal law and Humana's policies and procedures.
- This attestation requirement is intended to be completed at the contract level. That is, if every practitioner in an organization has a direct contract with Humana, then each practitioner must complete the required attestation. However, if a practitioner is contracted with Humana through a group contract, then each practitioner must complete the training and coordinate within the organization to have the person responsible for compliance complete the required attestation.
- Please note that if an organization provides multiple functions for Humana, its compliance contact may receive an additional notification from Humana. The organization is only required to complete this requirement once.
- More information is available in the frequently asked questions and answers document located here (http://apps.humana.com/marketing/documents.asp?file=1827553).

Questions about these requirements may be directed to Humana Provider Relations at 1-800-626-2741.

If a physician or practitioner suspects or becomes aware of potential noncompliance and/or fraud, waste and abuse, he or she may report it immediately utilizing the Ethics Help Line at 1-877-5 THE KEY (1-877-584-3539) or the Ethics Help Line online reporting site at https://www.ethicshelpline.com.

Reminder: "Humana Pharmacy" Now Available for Members

Humana's prescription mail-order pharmacy service, RightSource, is now known as Humana Pharmacy. Other than the name, nothing has changed.

Humana Pharmacy is continuing RightSource's service of shipping a three–month supply of maintenance medications to patients via mail. The high level of service, commitment, quality and affordable cost is the same that our customers and their prescribers have come to expect.

Humana has informed its members of the name change via packaging inserts in their current prescriptions, and in letters, emails and online posts on myhumana.com (http://myhumana.com/ — registration required) and

Humana.com (http://www.humana.com/). Prescribers may have patients come to them with questions about the change.

How to find Humana Pharmacy in e-prescribing software

Humana is using transitional naming to help prescribers find Humana Pharmacy/RightSource in their e-prescribing software. The name switch to Humana Pharmacy will be complete in September 2015.

Currently, Humana Pharmacy displays as:

- Humana Mail Delivery-RightSourceRx
- Humana Specialty-RightSource Spec

In September, Humana Pharmacy will appear as:

- Humana Pharmacy Mail Delivery
- Humana Specialty Pharmacy

The e-prescribing process itself has not changed. The only change a prescriber will notice is the name listed in his or her e-prescribing software, as noted above.

For more information about Humana Pharmacy, prescribers can call 1–800–379–0092, Monday through Friday, 8 a.m. to 11 p.m., and Saturday, 8 a.m. to 6:30 p.m. Eastern time.

Online Tools, Presentations, Webinars Provide Important Tips to Physicians, Staff

Humana adopts clinical practice guidelines based on guidance from national organizations generally considered experts in their fields. *Humana's YourPractice* features updates to these clinical practice guidelines as well as newly adopted guidelines. Humana intends to provide timely information about evidence-based best practices for patient care and to help improve quality measures and Stars scores. While many guidelines are updated annually, others may not change for several years. Humana encourages physicians and other practitioners to look for these clinical practice guideline notifications in *Humana's YourPractice*. Medical and behavioral health clinical practice guidelines are available here (http://www.humana.com/providers/clinical/clinical_practice.aspx).

Updated current clinical practice guidelines:

- Adult Immunizations (2014)
- Childhood Immunizations (2014)
- Hypertension (2014)
- Preventive Care (2014)
- Colorectal Cancer (2014)

- Valvular Heart Disease (2014)

Newly added clinical practice guidelines (2014)

- Smoking Cessation (Treating Tobacco Use and Dependence: 2008 Update – Clinical Practice Guideline)
- Cholesterol Management (2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines).

New and revised pharmacy and medical coverage policies

Humana's medical and pharmacy coverage policies are based on evidence published in peer-reviewed medical literature, technology assessments obtained from independent medical research organizations, evidence-based consensus statements and evidence-based guidelines from nationally recognized professional health care organizations.

Information about medical and pharmacy coverage policies can be found at **Humana.com/provider** (http://www.humana.com/provider) by selecting "Medical and Pharmacy Coverage Policies" under "Resources." Medical and pharmacy coverage policies can be reviewed by name or revision date. Users may also search for a particular policy using the search box. More detailed information may be found by reviewing "How to Read a Medical Coverage Policy" and "Understanding the Medical Coverage Policy Development Process."

Below are the new and revised policies:

New pharmacy coverage policies

- Corlanor (ivabradine)
- Esbriet (pirfenidone)
- Farydak (panobinostat)
- Mircera (methoxy polyethylene glycol-epoetin beta)
- Namzaric (donepezil and memantine)
- Natpara (parathyroid hormone)
- Ofev (nintedanib)

Pharmacy coverage policies with significant revisions

- No pharmacy coverage policies with significant revisions

New medical coverage policies

- Genetic testing for muscular dystrophy and spinal muscular atrophy

Medical coverage policies with significant revisions

- Blepharoplasty
- Breast imaging
- Breast reconstruction

- Breath tests for airway inflammation and gastric emptying
- Chronic vertigo evaluation and treatment
- Cochlear implants, auditory brainstem implants
- Gastroesophageal reflux disease (GERD) treatments
- Genetic testing for cardiac conditions
- Genetic testing for diagnosis and monitoring - noncancer indications
- Pharmacogenomics - cytochrome P450 polymorphisms and VKORC1
- Physical therapy (PT) and occupational therapy (OT)
- Platelet derived growth factors for wound healing
- Prosthetics
- Rheumatoid arthritis: biologic markers and pharmacologic assessment
- Skin and tissue substitutes
- Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT)
- Transcranial magnetic stimulation (rTMS) and cranial electrical stimulation

Retired medical coverage policies

- No retired medical coverage policies

Online information makes it easier to do business with Humana

Humana's "Education on Demand" tool provides physicians, other practitioners and their office staff with quick, easy-to-understand information on topics that should simplify doing business with Humana.

To access this tool, health care providers may choose: https://www.humana.com/provider/support/on-demand/. If a computer with a sound card is not available or if the computer is not configured for streaming audio, the presentations may be accessed via telephone while viewing the slides on screen. To begin the telephone playback process, health care providers should follow these steps:

- Click on the question mark in the bottom right corner
- Select "Player Settings" from the pop-up box
- Check "Use telephone playback with standard player"
- Click the "Submit" button
- A window will open displaying the telephone number and access code needed to hear the audio presentation

Available topics are as follows:

- Commercial Risk Adjustment

- HumanaAccess℠ Visa Card
- Humana Member Summary
- HumanaVitality®
- Making It Easier for Health Care Providers
- Special Needs Plans (SNPs)
- Texas Deficiency Tool
- Working with Humana
- RadConsultTM Online
- SmartSummary® Rx

Humana's claims education page includes educational tools that help health care providers better understand Humana's claims policies and processes. To access the tool, physicians and health care providers can visit http://humana.com/healthcareproviderhowto.

The page, which will be updated with new content each month, has brief education-on-demand computer-based presentations that include a printable tip sheet with the most important information about each topic. Current topics include:

- Medicare preventive services
- Humana's approach to National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Proper use of anatomical modifiers
- Modifier 25
- Modifiers 59 and X {EPSU}
- Procedure-to-Procedure Code Editing
- Modifier 24
- Humana's Approach to Code Editing

The presentations can be accessed around the clock.

Webinars provide interactive learning

The webinar sessions below will assist physicians and other health care providers in learning how to utilize **Humana.com** (http://www.humana.com/) to save time, increase efficiency and help improve the productivity of their practices. These sessions for office staff last between 45 minutes and one hour.

2015 practitioner webinar training schedule

Eligibility and benefits

This webinar covers submitting online requests for verification of a patient's eligibility and benefit information, including covered services, copayment and deductible information. Participants will also learn about the member

ID card viewer, member summary and Humana's new benefit estimator tool, which provides a real-time estimate of a patient's payment responsibility for professional services.

- Thursday, Aug. 20 at 11 a.m. EST
- Tuesday, Sept. 15 at 2 p.m. EST

Referral/authorizations
With the referral and authorization tool, health care providers can easily submit requests for both inpatient and outpatient services. This webinar will cover how Humana's authorization management tool can help physicians and their staff check the status and make changes to existing referrals and authorization requests.

- Tuesday, Sept. 1 at 2 p.m. EST

Claim tools and remittances
This webinar covers how to reconcile and manage accounts receivable by reviewing claims status, results and remits online. Physicians, other practitioners and their staff will learn how to make corrections to professional claims, send attachments and view and download remittance advice.

- Thursday, Aug. 13 at 2 p.m. EST
- Tuesday, Sept. 8 at 2 p.m. EST

Medical records management
The medical records management (MRM) tool allows providers to view requests made by Humana for most medical records. This webinar reviews how to manage, submit and close these requests.

- Thursday, Aug. 27 at 2 p.m. EST
- Tuesday, Sept. 22 at 11 a.m. EST

How to register

To register, visit **Humana.com/providerwebinars** (http://humana.com/providerwebinars).

Confirmation and instructions on how to access the online webinar will be sent via email within 48 hours of the request.