Humana's YourPractice

RightSource® Renamed "Humana Pharmacy™"

RightSource, the Humana-owned mail-delivery pharmacy, is being renamed Humana Pharmacy this month. Other than the name, nothing is changing. Humana Pharmacy is continuing RightSource's service of shipping a three–month supply of maintenance medications to patients by mail. The high level of service, commitment, quality and affordable costs is the same that Humana members and their prescribers have come to expect.

RightSource has informed its customers of the name change via packaging inserts with their current prescriptions, with letters and emails and digitally with posts on myhumana.com (https://www.humana.com/registration/ registration required) and **Humana.com** (http://www.humana.com/). Prescribers may have patients come to them with questions about the change. It's for this reason that Humana is making prescribers aware that RightSource pharmacy is now known simply as Humana Pharmacy.

Why change the name?

Many Humana members may not be aware that RightSource is, in fact, fully owned by Humana. As a result, Humana members are hesitant to use the service, thus missing out on the potential savings and convenience RightSource provides. RightSource already is the "Humana Pharmacy"—this name change simply highlights that.

How can Humana Pharmacy (formerly RightSource) benefit prescribers and their patients?

Humana recognizes that patients must determine which pharmacy will best meet their prescription needs and that physicians play a role in their decision. Some of the features Humana Pharmacy offers are:

- **Potential cost savings:** With 90–day pricing and low–cost alternatives, Humana Pharmacy may help reduce Humana–insured patients' prescription drug costs. Some Medicare patients may receive Tier 1 generic medications for a $0 copayment. Prescribers can ask patients to check their health plan materials to find out if this pricing is offered in their plan.

- **Making adherence easier:** Humana Pharmacy notifies patients by email, phone or text message when their prescriptions need to be refilled and when their refills are about to run out. Patients avoid trips to the pharmacy, making it easier to adhere to their therapy.

- **Accuracy and safety:** Two Humana Pharmacy pharmacists review each new prescription for accuracy and possible drug–to–drug or drug–to–disease interactions. Advanced technology helps ensure accurate medication dispensing. Humana Pharmacy uses foil–sealed containers to prevent tampering.

How to find Humana Pharmacy in e-prescribing software

The RightSource name is gradually transitioning to Humana Pharmacy to help prescribers find Humana Pharmacy/ Rightsource in their e-prescribing software. The switch to the name Humana Pharmacy will be complete in September 2015. The following timeline details how Humana Pharmacy appears in e-prescribing software:

- April 2015
  - RightSourceRx-Humana Mail Delivery
  - RightSource Specialty-Humana Spec

- June 2015
  - Humana Mail Delivery-RightSourceRx
  - Humana Specialty- RightSource Spec

- September 2015
  - 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/RightSource, 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.

Humana recognizes that members have the sole discretion to choose their pharmacy. Prescribers must use their independent medical judgment when advising patients about their pharmacy choices. Other pharmacies are available in Humana's network.

Learn More about Claims Policies and Processes on New Humana.com Page

Humana.com (http://humana.com/healthcareproviderhowto) now hosts a new claims education page for all physicians and health care providers at humana.com/healthcareproviderhowto. The page includes educational tools that help health care providers better understand Humana's claims policies and processes.

Brief education-on-demand presentations focus on a specific topic, including a printable tip sheet with the most important information about that 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.

Humana plans to add new content to the page each month.

Humana encourages input on future topics, along with clinicians' and their office staff members' opinions regarding the quality of the content and how the information is presented. Each video presentation includes a survey at the end for feedback.

For more information, please see humana.com/healthcareproviderhowto or call Humana at 1-800-448-6262, Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

Healthy Days Helps Humana Measure Population Health

Dear physicians and health care providers:

There is no shortage of tools for measuring health. There are biomarkers, readmission rates, emergency room visits, medication adherence, data from wearable devices like Fitbits and Garmins. The list goes on.

Yet all this data might not be enough to answer a very simple, but important question: How do people feel?

As an oncologist who practiced medicine for more than 22 years, I often learned much more from asking my patients how they felt than I did from evaluating lab values and diagnostic tests. To quantify the health of large populations, data tell us only part of the story. It's also important to know how patients are feeling.

Enter Healthy Days

A team of Humana clinical and analytics leaders, along with national public health experts, reviewed existing measures of population health, seeking a measure that is reliable, actionable, externally recognized, clinically relevant and simple.

The team determined that the U.S. Centers for Disease Control and Prevention measure known as "Healthy Days" was the most appropriate measure for us to use in tracking progress toward Humana's bold goal of making the communities we serve 20 percent healthier by 2020.

Healthy Days asks people about general self-rated health and includes a total of four questions. Two of these questions focus on physical and mental health over the previous 30 days and are used to derive an index of unhealthy days.

Those questions are:

1. Now, thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
2. Now, thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?

This questionnaire has been shown to provide a holistic view of a person's health and to capture perceptions of health regardless of age, gender, race or health condition. In addition, self-assessed health status has been proven to be a more powerful predictor of mortality and morbidity than many clinical measures of health.

We're already learning some important things

At the American College of Preventive Medicine Annual Meeting in Atlanta, Humana researchers presented the first in a series of studies on Healthy Days.

This first study shows that people who were compliant with preventive health screenings had fewer unhealthy days. For example, women who had breast cancer screenings had fewer unhealthy days than those who didn't. The study also shows that people who keep their "numbers" at goal have fewer unhealthy days. In fact, people with heart disease or diabetes who kept their total cholesterol under 100 mg/dL had two fewer unhealthy days per month.

View the full research here (http://apps.humana.com/marketing/documents.asp?file=2615002).

Here's to more Healthy Days for us all.

Sincerely,

Roy Beveridge, M.D.
Chief Medical Officer
Humana

Humana Provides Guidance on Genetic Testing

Dear physicians and health care providers:

Genetic testing comprises only a small percentage of all laboratory tests prescribed for our members, but includes some of the most complex laboratory tests available to members and their families.

The complexity of genetic testing is influenced by many factors, including:

- Testing may be marketed prior to being fully validated, and clear guidance of how to use the testing to impact treatment decisions may not yet exist.
- A thorough family history may not have been completed.
- A study of if and how the testing compares to the current standard of practice may not have been completed.
- Limited access to genetic expertise is available.

All of these factors must be considered when determining the best testing approach for an individual. To facilitate appropriate genetic testing for our members, we developed the genetic guidance program (GGP).

The GGP helps the member receive the right genetic test to promote positive health outcomes. Composed of a team of board-certified genetic counselors and nurses, the GGP, along with Humana's medical directors, review genetic testing preauthorization requests. The goal of the program is to ensure that the test results provide meaningful clinical information for our members.

The emphasis for the GGP is on the following:

- Educating physicians and members about evidence-based use of a genetic test.
- Redirecting to a better test based on the individual circumstances, if appropriate.
- Redirecting to an equivalent in-network laboratory in order to help the member save money, if appropriate.

Along with its guidance in making health care decisions, the GGP seeks to provide professional genetic expertise that promotes education and transparency around genetic testing.

Preauthorization is required for genetic testing (for exclusions, log on to the secure provider portal at **Humana.com**). The preauthorization process includes evaluation of peer-reviewed medical literature, professional society organization recommendations, Humana medical coverage policies, Medicare coverage policies and/or other applicable resources. Based on the clinical and family history provided by the physician's office and this research, an individualized preauthorization request is reviewed and a determination is made, along with relevant recommendations.

Humana's GGP understands that genetic testing and the technologies around it continue to evolve at a rapid rate. As new tests become clinically available, our GGP associates review new literature, technologies and professional society guidelines. We understand how busy physician practices are. The GGP has dedicated resources to stay abreast of the changes in this testing area and uses this expertise each day when working with physician practices.

To submit a genetic testing preauthorization request, contact Humana at 1-800-523-0023 or log into Humana's secure provider website at **Humana.com** or www.availity.com (registration required).

Sincerely,

Bryan Loy, M.D., MBA
Market Vice President, Oncology and Lab Strategies

New ID Card Option Available to Members

Humana members will soon have the convenience of a digital member ID card in addition to physical member ID cards. **Please note: Humana members will continue to receive physical member ID cards.** Digital ID cards are available as an option for members; they are not replacing physical member ID cards.

Your patients with Humana coverage may present a digital member ID card on their smartphone, instead of a physical member ID card. Patients may also choose to print a paper version from their MyHumana ID Card Center or

to fax a copy of the card to your office from their smartphone. We respectfully request that you accept a digital, fax or printed version of these patients' ID cards when they visit your office for care.

For more information, refer to these frequently asked questions and answers (http://apps.humana.com/marketing/documents.asp?file=2630953).

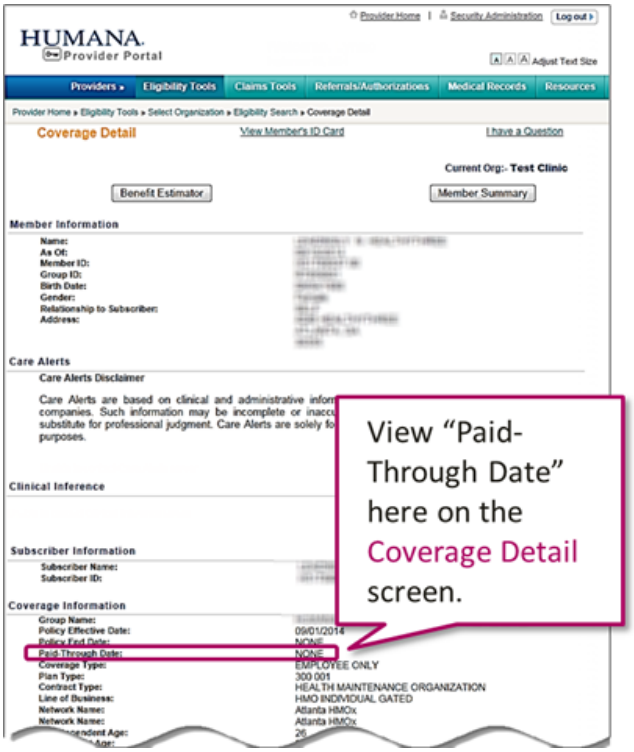
Paid-through Dates Available on Humana.com

Physicians and practitioners can now obtain the paid-through date for both on- or off-exchange marketplace members via the secure provider Web portal on **Humana.com**. Also, grace period statuses for members are available via the interactive voice response (IVR) system. Both tools have been enhanced to provide more information about the eligibility status of Humana members who are on the health insurance marketplace.

To access the paid-through date online:

1. Sign into the secure provider portal on **Humana.com**.
2. Click on the "Eligibility & Benefits" icon.
3. Search for the patient by entering the patient's Humana member ID.

Practitioners will see the paid-through date, if available, on the "Coverage Detail" page, under the "Coverage Information" heading. (See image below.)



To access grace period information via IVR:

1. Call the phone number on the back of the member's Humana member ID card, or call 1-800-4HUMANA (1-800-448-6262).
2. Enter the provider ID (federal tax ID) or NPI for verification purposes, as prompted.
3. Follow the prompts to request the member's eligibility and benefit information. If the member is in the grace period, the IVR system will state that "claims may be denied since the member is in the grace period."

Future enhancements

Humana is continuing to enhance the information that is available on the secure provider portal of **Humana.com** and the IVR. Humana also is working to provide this information on Availity.com's secure provider Web portal and electronic data interchange (EDI) transactions.

For updates on future enhancements, please visit the What's New section on **Humana.com** (http://www.humana.com/provider/medical-providers/education/whats-new/paid-through-date).

For questions about member eligibility, practitioners can call the phone number on the back of the member's Humana member ID card, or 1-800-4HUMANA (1-800-448-6262). Members who have questions pertaining to paid-through date status can call the number found on the back of their Humana ID card.

CMS Requires Notification of Termination of SNF, HHA and CORF Services

The Centers for Medicare & Medicaid Services (CMS) requires that physicians and other health care providers give the Notice of Medicare Non-Coverage (NOMNC) to Medicare Advantage (MA) health plan members at least two days prior to termination of skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Additionally, if the member's SNF services are expected to be fewer than two calendar days, the NOMNC should be delivered at the time of admission. For HHA or CORF services, the notice needs to be given no later than the next to the last time services are furnished.

The NOMNC informs members how to request an expedited determination from their quality improvement organization (QIO) if they disagree with the termination.

In order for the NOMNC to be valid:

- The member must be able to comprehend and fully understand the notice contents.
- The member or his or her authorized representative must sign and date the notice as proof of receipt.
- The notice must be the standardized CMS NOMNC form.
    - The form and instructions regarding the NOMNC are available on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html.

  - Practitioners also may contact their QIO for forms or additional information.
  - A form may also be obtained from Humana's local health services utilization management department.
  - No modification of the text on the CMS NOMNC is allowed.
- If a member refuses to sign the NOMNC, the member's refusal to sign, the date, time, name of person who witnessed the refusal and his or her signature must be documented on the NOMNC.

Valid delivery does not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Any assistance used with delivery of the notice also must be documented.

If a member is not able to comprehend and fully understand the NOMNC:

- When a representative assumes responsibility for decision-making on the member's behalf, the representative, in addition to the member, must receive all required notifications.
- The following specific information is required to be given when contacting a member's representative of the NOMNC by phone:
  - The member's last day of covered services, and the date when the beneficiary's liability is expected to begin.
  - The member's right to appeal a coverage termination decision.
  - A description of how to request an appeal by a QIO.
  - The deadline to request a review, as well as what to do if the deadline is missed.
  - The telephone number of the QIO to request the appeal.
- The date when the information is verbally communicated is considered the NOMNC's receipt date. Practitioners must document the telephone contact with the member's representative on the NOMNC on the day that it is made, indicating that all of the previous information was included in the communication. The annotated NOMNC also should include:
  - The name of the staff person initiating the contact.
  - The name of the representative contacted by phone.
  - The date and time of the telephone contact.
  - The telephone number called.
- A dated copy of the annotated NOMNC must be placed in the member's medical file, a copy mailed to the representative the same day as the telephone contact and a copy faxed to the practitioner's local Humana health services utilization management department.

NOMNC fast-track appeal

CMS offers fast-track appeal procedures to Medicare enrollees, including MA members, when coverage of their SNF, HHA or CORF services are about to end. CMS contracts with QIOs to conduct these fast-track appeals. When notified by Humana or the QIO that the member has requested a fast-track appeal, practitioners must:

- Provide medical records and documentation to Humana and the QIO, as requested, no later than close of the calendar day on which they are notified (This includes, but is not limited to, weekends and holidays.)
- Deliver the Detailed Explanation Non-Coverage (DENC) form that is provided by Humana (or that is delegated to the practitioner to complete) to members (or their authorized representatives) no later than close of the calendar day on which they are notified. (This includes, but is not limited to, weekends and holidays.) The DENC provides specific and detailed information concerning why the SNF, HHA or CORF services are ending.

If a member misses the time frame to request an appeal from the QIO, the member still can 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/MAEDNotices.html.

Consider APAP for Patients with Obstructive Sleep Apnea

Humana encourages physicians to consider prescribing auto-titrating positive airway pressure (APAP) treatment for their Humana-covered patients diagnosed with obstructive sleep apnea (OSA) to improve patients' comfort.

As opposed to continuous positive airway pressure (CPAP) treatment, which can only be set to one predefined pressure setting that remains consistent throughout hours of sleep, APAP devices are able to automatically adjust (within a range of 4-20 cm H2O) based on an individual's needs. APAP devices do not require a facility-based titration.

APAP improves comfort for most patients because it automatically adjusts the pressure upwards (slowly over a series of breaths) as the device senses increased airway resistance or increased vibration and also lowers the pressure as the airway begins to relax.

In addition to adjusting pressure throughout the night, APAP helps patients whose night-to-night pressure needs change depending on their sleeping situation and other factors, such as a change in body position during sleep, stage of sleep, congestion from allergies/illness, medications, alcohol consumption or weight loss or gain.

As with any therapy, APAP may not be appropriate for all patients. Those with significant comorbidities, such as chronic obstructive pulmonary disease, Cheyne-Stokes respiration, neuromuscular disease and restrictive lung disease, may not be candidates for APAP.

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

General

- American Academy of Professional Coder (AAPC) ICD-10 training: http://www.aapc.com/icd-10/training.aspx
- American Health Information Management Association (AHIMA) ICD-10 training: http://www.ahima.org/education/onlineed/Programs/ICD10

Coders

- **AAPC coder proficiency assessment**
  AAPC members holding CPC®, COC™, CPC-P®, CPC-I® medical coding certifications must demonstrate proficiency in ICD-10-CM by Dec. 31, 2015, in order to maintain their credentials. The assessment (available at http://www.aapc.com/icd-10/icd-10-proficiency-assessment.aspx) is $60. It contains 75 multiple-choice questions and is open book, online and unproctored with a 3.5-hour time limit.

- **Top Coders**
  ICD-10 contains more than 69,000 diagnosis codes, compared with about 14,000 in ICD-9. While clinicians will not need to know them all, they will need to be familiar with the changes that impact their practices. Humana recommends starting with a list of a practice's commonly used ICD-9 codes and developing a list of viable ICD-10 codes.

- **Crosswalks for the top 50 codes by specialty**
  The AAPC has crosswalked the top 50 ICD-9 codes to the latest ICD-10 codes for more than 15 specialties, so clinicians can become familiar with the level of specificity required in their documentation. Printable lists of the top codes by specialty are free with registration and are available at http://www.aapc.com/ICD-10/crosswalks/pdf-documents.aspx.

- **Content-based testing**
  Use practical application and code medical scenarios in ICD-10 with Humana's professional provider content-based testing. Clinicians and coders can register for one or multiple specialties, read clinical scenarios, submit ICD-10 diagnosis codes for feedback and view peer reports. Register for Humana's professional provider content-based testing at http://hureg.providercodingimpact.com/Registration.aspx

Physicians

- **AHIMA documentation tips**
  The AHIMA CDI Workgroup created a library of tips for improving ICD-10 clinical documentation. The tips focus on the language and wording that will generate greater details and specificity of the coded data for a given diagnosis, condition, disease and/or surgical procedure. The tips are available at http://bok.ahima.org/PdfView?oid=300621.

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.

Professional and Facility Claim Code Edits Continue

Humana continues to update its claim payment systems to better align with correct-coding initiatives, Centers for Medicare & Medicaid Services (CMS) guidelines, national benchmarks and industry standards regarding professional and facility claims.

These changes occur via a phased approach with implementations and Web postings on the following dates:

Implementation Dates	Dates Available to View on Humana.com
Jan. 26, 2015	Oct. 24, 2014
April 13, 2015	Jan. 9, 2014
June 22, 2015	March 21, 2015
Sept. 14, 2015	June 12, 2015
Nov. 9, 2015	Aug. 7, 2015

A detailed list of the changes is available on the provider section of Humana.com 90 days prior to the implementation date, as indicated in the above grid. To review these changes, visit https://www.humana.com/provider/medical-providers/education/claims/processing-edits.

Time to Complete 2015 Provider Compliance Training Materials

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, which requires Internet access. To access the website, health care providers must be registered on **Humana.com/**

additional information on completing these requirements, including registration, are available here (https://www.humana.com/provider/medical-providers/education/whats-new/compliance-requirements). 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 Web reporting site at https://www.ethicshelpline.com.

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

Humana adopts clinical practice guidelines based on guidance from national organizations generally accepted as experts in their fields. *Humana's YourPractice* features updates to these clinical practice guidelines and newly adopted guidelines. Humana's intent is to provide timely information about evidence-based best practices for patient care as well as 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 clinical practice guidelines

- Updates to current guidelines include:
- Adult Immunizations (2014)

- Hypertension (2014)
- Preventive Care (2014)
- Colorectal Cancer (2014)
- Valvular Heart Disease (2014)

Newly added clinical practice guidelines

- Clinical practice guidelines adopted in 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 on **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, as well as 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

- Cosentyx (secukinumab)
- Iluvien (fluocinolone acetonide intravitreal implant)
- Lenvima (lenvatinib)
- Opdivo (nivolumab)
- Pazeo (olopatadine)
- Toujeo (insulin glargine, U-300)

Pharmacy coverage policies with significant revisions

- No pharmacy coverage policies with significant revisions

New medical coverage policies

- No new medical coverage policies

Medical coverage policies with significant revisions

- Airway clearance devices
- Bone growth stimulators
- Continuous passive motion (CPM) and mechanical stretching devices
- Genetic testing for spinocerebellar ataxia
- Intensity modulated radiation therapy (IMRT)
- Transcatheter valve implantation

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 members with quick, easy-to-understand information on topics that should make it easier for them to do business with Humana.

To access, 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 are available over the 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 that need to be dialed to receive the audio

Available topics are as follows:

- Commercial Risk Adjustment
- Humana*Access*℠ Visa Card
- Humana Member Summary
- HumanaVitality®
- Making It Easier for Health Care Providers
- Special Needs Plans (SNPs)
- Texas Deficiency Tool
- Working with Humana

- RadConsult™ Online
- SmartSummary® Rx

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** 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 teaches how to submit online requests for verification of a patient's eligibility and benefit information. Instant results include 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, July 23 at 2 p.m. EST
- 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 teach 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, July 7 at 2 p.m. EST
- Thursday, Aug. 6 at 11 a.m. EST
- Tuesday, Sept. 1 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 teaches how to manage, submit and close these requests.

- Tuesday, July 28 at 2 p.m. EST
- Thursday, Aug. 27 at 2 p.m. EST
- Tuesday, Sept. 22 at 11 a.m. EST

How to register

To register, send an email to ebusiness@humana.com.

When registering, please include the following information in the subject line of the email:

Webinar registration – DATE OF TRAINING (ex: 10/20/14)

Please also include the following information within the email:

- Name of main participant
- Practice name
- Phone number
- Email address(es) of participant(s)
- Tax ID number
- Number of participants attending the webinar

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