Humana's YourPractice

Humana Announces Changes to 2015 Formularies

Beginning Jan. 1, 2015, certain drugs will have new limitations or will require utilization management under the Humana commercial and Medicare formularies for the 2015 plan year. These changes could mean higher costs or new requirements for Humana members who use these drugs. Humana encourages the use of generic and cost-effective brand medications whenever possible.

Formulary changes

Below are links to charts that show some commonly used medications that will be impacted by the Humana commercial and Medicare formulary changes in 2015 (e.g., prior authorization (PA) requirements, step therapy (ST) modifications and nonformulary (NF) changes). Prescribers may receive questions from their patients about possible alternatives.

Commercial formulary changes: View a list of some commonly used medications (http://apps.humana.com/marketing/documents.asp?file=2549495) that will be impacted by Humana commercial formulary changes in 2015 (e.g., prior authorization (PA) requirements and step therapy (ST) modifications).

For prescription drug information for Humana commercial members, health care providers may visit our website at https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/drug-list. Click "Drug list search" and enter the drug name. Choose "Commercial" to see the drug's tier placement in commercial formularies and any restriction that may apply.

Medicare formulary changes: View a list of formularies containing some commonly used medications (http://apps.humana.com/marketing/documents.asp?file=2549638) that will be impacted by Humana Medicare formulary changes in 2015 (e.g., prior authorization (PA) requirements, step therapy (ST) modifications and nonformulary (NF) changes).

For prescription drug information for Humana Medicare members, health care providers may visit https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/drug-list. Click "Drug list search" and enter the drug name. Choose "Medicare" to see the drug's tier placement in Medicare formularies and restrictions that may apply.

High-risk medication updates: High-risk medications (HRMs) have the potential to be problematic in those 65 years of age or older. View a list of formularies containing some commonly used HRMs (http://apps.humana.com/marketing/documents.asp?file=2549456) that will be impacted by Humana Medicare formulary changes in 2015.

If health care providers have questions regarding these changes, they may call 1-800-457-4708. This line is open from 8 a.m. to 8 p.m. local time, Monday through Friday.

Humana's Quality Rewards Program Distributes $76 Million to Physicians

Dear Health Care Provider:

At Humana, we pay bonuses to physicians who improve the quality of care for our members. For instance: some 4,700 physician practices in our Quality Rewards Program received bonuses based on quality measures they achieved when treating our Medicare members during the 2013 plan year.*

These bonuses totaled nearly $76.8 million, a 28 percent increase from the $60 million we previously distributed to physicians participating in the program. We are proud of our Quality Rewards Program, which is part of our accountable care continuum that promotes evidence-based, high-quality care through a variety of bonus programs.

We also recently announced Star ratings for our Medicare Advantage (MA) plans. One MA plan – our CarePlus Health Plans, Inc. HMO plan in Florida – achieved a rating of 5.0 stars. In addition:

- Nine Humana MA plans achieved a 4.5 star rating
- 23 Humana MA plans achieved a rating of 4.0 stars or greater

The focus on improving quality supports more physician practices as they move into value-based relationships, while also improving the member experience. This holistic approach to patient care not only helps physicians and clinicians focus on the total health of their patients, but also reflects the importance of moving from sick care to health care. For more information call provider relations at 1-800-626-2741 or email providerengagement@humana.com.

Sincerely,

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

* The reward finalization takes place in 2014 for the 2013 Rewards Program, to allow time for final claims submission and supplemental data. The 2013 reward payments to physician practices were based on the practices' ability to improve quality for many National Committee for Quality Assurance (NCQA) preventive and chronic-condition management Healthcare Effectiveness Data and Information Set (HEDIS) measures including, but not limited to, the following:

- Breast cancer screening
- Colorectal screening
- Glaucoma screening
- Diabetes treatment management
- High-risk medications review for the elderly
- Cholesterol screening
- Diabetes blood sugar control

- Nephropathy screening
- Diabetic retinal eye exam

Continuity of Care Emphasized as Key Goal

Dear Health Care Provider:

Improving members' health outcomes and well-being are key goals for Humana. One approach Humana stresses for improving the quality of health care is continuity of care, a team approach that emphasizes communication between all of a patient's health care providers. Continuity of care gives physicians better information about their patients' medical history, allowing them to communicate more effectively with a patient's other health care providers.

Continuity of care promotes the following benefits for members and health care providers:

- Improved coordination of health care resources
- More focus on patient-centric care
- Higher rates of preventive medicine
- Better record keeping
- Increased patient satisfaction with his or her health care provider

An example of continuity of care: when a specialist's office forwards the results of office visits and tests to a patient's primary care physician (PCP), the PCP's office can include the information in the patient's medical records for future reference. Humana encourages all of a member's health care providers to share information and recommends that referrals, past medical records, hospital records, operative and pathology reports, diagnostic studies, admission and discharge summaries, consultations and ER reports all be part of the medical records in the member's PCP office.

This effort ultimately works to help lower out-of-pocket expenses for the patient, as well as facilitates better health outcomes. Health care providers are encouraged to make sure that their administrative staff is aware of the importance of continuity of care and that reports are being distributed and followed up on in a timely manner.

For more information about Humana's continuity of care or other quality improvement programs, health care providers can call 1-800-4HUMANA (1-800-448-6262).

Sincerely,

Philip Painter, M.D.
Chief Medical Officer
Humana Health Guidance Organization

Humana Offers Claim Submission Guidance for Well Woman Visits

Dear Physicians and Office Staff:

Humana encourages its female members to receive their preventive physical exam/Well Woman Visit as a key tool to help them manage their health. The following guidelines should help obstetricians/gynecologists correctly code these visits for commercial and Medicare Advantage (MA) plan claims:

- A Well Woman exam should be submitted with Healthcare Common Procedure Coding System (HCPCS) codes Q0091 and/or G0101:
    - **HCPCS code Q0091** (Screening papanicolaou (pap) smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory)
    - **HCPCS code G0101** (cervical or vaginal cancer screening; pelvic and clinical breast examination)
- An obstetrician/gynecologist who functions as a primary care physician (PCP) may submit a charge for an initial or periodic comprehensive preventive medicine evaluation using a 9938x or 9939x Current Procedural Terminology (CPT®) code only when all of the components of the annual preventive physical exam were performed. (Please reserve the 9938x and 9939x CPT codes for reporting annual preventive physical exams. These codes can only be billed once per calendar year.)
- An evaluation and management (E&M) service is not separately reportable, unless the visit is unrelated to the Well Woman exam. If the services are unrelated, then the E&M service may be reported by appending a modifier to the E&M service code.

Please note: Humana covers a Well Woman visit once every 24 months or once every 12 months for women at high risk and for women of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past 3 years.

Additional information about claims code editing is available via the "Code Editing Questions" application on the secure provider area of Humana.com/providers (https://www.humana.com/logon) (registration required). Health care providers may follow these steps to submit code edit questions:

- On Humana.com/providers (https://www.humana.com/logon), select the "Sign in or Register" link
- Enter username and password and select "Sign in"
- On the "Claims Tools" tab:
    - select "Code Editing Questions"

Learn More about Multiple Procedure Payment Reduction (MPPR)

Effective Sept. 13, 2014, Humana plans apply multiple procedure payment reduction (MPPR) for diagnostic cardiovascular services, diagnostic ophthalmology services, diagnostic imaging (radiology) services and therapy

practice expense (PE). MPPR is a reduction to a portion of the base allowable amount for a service (or a component of service) when more than one unit or procedure of a particular type is provided to the same patient on the same date of service. MPPR applies only to multiple procedures and multiple units.

Covered practitioner services are often priced based on the "inputs" involved in performing the services, such as labor, utilities and supplies. A widely recognized way of calculating pricing involves grouping inputs into three categories: work, malpractice and practice expense (PE).

When multiple services are rendered to a patient by a provider on the same day, some clinical labor activities and supplies that are common to multiple services are not separately provided for each service; so it is appropriate to offset the pricing of services to account for that fact. MPPR adjusts pricing in these situations.

How does Humana apply an MPPR?

Humana applies MPPR for certain services in order to more appropriately recognize the efficiencies health care providers experience when combinations of services are provided together.

For therapy practice expense (PE) MPPR, full payment is made for the unit or procedure with the highest PE payment; all subsequent units and/or procedures are paid at a reduced amount for the PE portion of the services. For other MPPRs, full payment is made for the component (technical or professional) with the highest payment; all subsequent units and/or procedures are paid at a reduced amount for the specific component.

When does Humana apply MPPR?'

In most cases, Humana applies MPPR at the time of initial adjudication or redetermination. This provides more accurate initial processing of claims and reduces the need to recoup payments after initial processing.

The following are some procedures with examples of when and how Humana applies MPPR to them:

- **Diagnostic cardiovascular services** — MPPR applied to the technical component.
- **Diagnostic ophthalmology services** — MPPR applied to the technical component.
- **Diagnostic imaging (radiology)** — MPPR applied to the technical and professional components.
- **Therapy — practice expense**
  For current dates of service, Humana applies a 50 percent MPPR to the practice expense (PE) payment of "always therapy" services. The following table shows a sample calculation of therapy PE MPPR. Note that one unit allowed "always therapy" services is not subject to the MPPR; however, for six units of allowed "always therapy" services, only five units are reduced.

	BA*	PE*	Total reduction calculation (for office or other noninstitutional setting)	Total allowed amount (assuming no other reductions)
Procedure code 1	$30	$0.5	**3** (units) X $ 0.50 X **50% =** **$ 0.75 reduction**	3 (units) X $30.00 = $90.00 (0.75) **$89.25**
Procedure code 2	$29	$1.00	**2** (units) X $ 1.00 X **50% =** **$ 1.00 reduction**	3 (units) X $29.00 = $87.00 (1.00) **$86.00**

* Base Allowable (per unit)

** PE Portion of Payment (per unit)

This article contains information about application of this rule in general. For more specific information, health care providers can access documents that detail the calculation of the PE portion of payment for "always therapy" services, as well as review previous notifications about MPPR, at Humana.com (https://www.humana.com/provider/medical-providers/education/claims/processing-edits). After choosing the appropriate "Compiled updates from 2008 to today" link, the health care provider may search for "MPPR."

Humana Identifies Top Coding Errors

Coding errors can result in reduced or delayed reimbursement and contribute to an incomplete record of a Humana member's health. Humana offers health care providers and their coding staff the following information on the most common coding errors and guidelines on how to avoid them:

1. **Incorrectly using current versus historical.**
   Avoid using the phrase "history of" to describe current or chronic conditions that are still present, active and ongoing. A medical condition described as "history of" means the condition was in the past and no longer exists. Coders should not code such conditions as current when it is not clear that the condition still exists. For example:

   - A patient has a current abdominal aortic aneurysm that is monitored with yearly abdominal ultrasounds to ensure the aneurysm is not increasing in size. The medical record documents "history of abdominal aortic aneurysm" with no other information. The medical coder should not code this condition as a current diagnosis, since it is documented as historical and not current.

   It is equally important for health care providers to refrain from documenting past conditions that no longer exist as if they are current. For example:

   - The final assessment includes "cerebrovascular accident (CVA)." A diagnosis code may be erroneously assigned for this condition as if it is current (434.91); when in reality, the patient experienced a cerebrovascular accident two years ago and has no residual deficits (V12.54). In this scenario, the condition really should have been documented as "history of cerebrovascular accident two years ago with no residual deficits."

   - A patient with a history of prostate cancer that has been eradicated in the past presents to the office for a six-month follow-up visit for evaluation, examination and lab test (prostate specific antigen, or PSA) to monitor for recurrence. The assessment section states "prostate cancer," which classifies to code 185 (the code for current prostate cancer). This is an error in documentation that results in an error in ICD-9-CM coding. The correct way to document this condition is "history of prostate cancer – PSA shows no evidence of cancer recurrence. Will continue to monitor PSA every six months to check for recurrence." History of prostate cancer classifies to code V10.46, personal history of malignant neoplasm of prostate.

2. **Failure to code to the highest level of specificity.**
   Medical coders must carefully review the entire medical record with attention to the details of a specific diagnosis description; for example, the coder must look for documentation of:

   - The specific site or location on the body or within a body part
   - The specific type or stage of the condition
   - Whether the condition is linked to another condition in a cause-and-effect relationship. It is incorrect to code two conditions as linked in a cause-and-effect relationship when the medical record documentation does not link them. The medical coder is not allowed to make assumptions and must code the conditions exactly as they are documented within the medical record. It is also incorrect to code two conditions separately when the medical record documentation links them in a cause-and-effect relationship. For example:
     - The medical record documents a diagnosis of "diabetes mellitus type 2, controlled" and separately documents a diagnosis of "peripheral neuropathy." Correct coding is:
       - 250.00: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled.
       - 356.9: Unspecified hereditary and idiopathic peripheral neuropathy.
     - The medical record documents a diagnosis of "diabetes mellitus type 2, controlled with peripheral neuropathy." Correct coding is:
       - 250.60: Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled.
       - 357.2: Polyneuropathy in diabetes.
     - Another example of lack of specificity in coding is:
       - The final assessment documents simply "breast cancer"; so, the coder assigns 174.9, Malignant neoplasm of breast (female), unspecified site. However, upon closer review, it is noted that the History of Present Illness documents a biopsy one week ago of a lump found in the upper, inner quadrant of the right breast, which was positive for adenocarcinoma. The most accurate ICD-9-CM code for this documentation is 174.2, Malignant neoplasm of upper-inner quadrant of female breast.

3. **Coding uncertain diagnoses as confirmed (in the outpatient setting).**
   Coders should be careful not to code an uncertain diagnosis as a confirmed diagnosis. The ICD-9-CM Official Guidelines for Coding and Reporting (Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services, I. Uncertain diagnosis) advises as follows:

   - Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results or other reason for the visit.

4. **Misinterpretation of abbreviations and acronyms.**
   Best documentation practice is for health care providers to limit the use of abbreviations or acronyms or

avoid them altogether. However, many health care providers freely use abbreviations and acronyms. Some standard abbreviations and acronyms have multiple meanings. The meaning of the abbreviation or acronym can often be determined based on context, but this is not always true. Thus, coding errors result. The following list includes examples of abbreviations and acronyms with multiple meanings that can lead to incorrect code assignment:

- AF — atrial fibrillation, atrial flutter.
- MI — myocardial infarction, mitral insufficiency, mitral incompetence.
- RA — rheumatoid arthritis, refractory anemia.
- MDD — major depressive disorder, manic depressive disorder.

Best practice documentation includes the following:

- The initial notation of an abbreviation or acronym should be spelled out in full with the acronym in parentheses. For example, "myocardial infarction (MI)" or "rheumatoid arthritis (RA)."
- Subsequent mention of the condition can be made using the acronym.
- The diagnosis should again be spelled out in full in the final impression or plan.

5. **Applying a clinical interpretation to medical record documentation.**
   Coders should avoid reading into or clinically intrepreting medical information or assigning a diagnosis that is not documented by the treating health care provider. For example:

   - The final impression in a medical record is chronic kidney disease (with no stage specified). The medical coder notes that the record documents a glomerular filtration rate (GFR) of 45. Since the coder knows a GFR within the 30 to 59 range equates to stage 3, code 585.3, chronic kidney disease stage 3, is assigned. This is not correct, as there is no documentation of stage 3 in the record. It is the health care provider's responsibility to document the stage of chronic kidney disease. When no stage is documented, code 585.9, chronic kidney disease, unspecified, must be assigned.

6. **Failure to code historical and status conditions**
   The ICD-9-CM Official Guidelines for Coding and Reporting read, "Personal and family history codes are acceptable on any medical record, regardless of the reason for the visit. A personal history of an illness, even when no longer present – or a family history of a condition – both represent important information that can influence patient care, treatment or management."

   Other excerpts from the ICD-9-CM Official Guidelines for Coding and Reporting include:

   - Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but has the potential for recurrence and therefore may require continued monitoring (with the exceptions of personal history of allergy to medicinal agents or to substances other than medicinal agents, e.g., a person who has had an allergic episode to a substance or food in the past should always be considered allergic to the substance).
   - Family history codes are used when a patient has a family member with a particular disease that causes the patient to be at higher risk of also contracting the disease.
   - Personal history codes may be used in conjunction with follow-up codes to explain the need for a test or procedure.

- Family history codes may be used in conjunction with screening codes to explain the need for a test or procedure.
- Status codes indicate that a patient is a carrier of a disease, has the sequelae (residual of a past disease or condition)or has another factor influencing his or her health status. An example includes the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code, which indicates that the patient no longer has the condition.

  A status code should not be used with a diagnosis code from one of the body system chapters if the diagnosis code includes the information provided by the status code. For example, code V42.1, heart transplant status, should not be used with code 996.83, complications of transplanted heart. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

For information on coding procedures, health care providers can access the "Code Editing Questions" application on the secure provider area of Humana.com/providers (http://www.humana.com/providers) (registration required). Health care providers may follow these steps to submit code edit questions:

- On Humana.com/providers (http://www.humana.com/providers), select the "Sign in or Register" link
- Enter username and password and select "Sign in"
- On the "Claims Tools" tab:
  - select "Code Editing Questions"

Remind Patients to Schedule Preventive Screenings

As we move into 2015, Humana asks health care providers to encourage their Humana-covered patients to get their preventive screenings, including the Welcome to Medicare Exam or annual physical/wellness exam on or before Dec. 31, 2015.

The new year is the perfect time to remind patients to make a resolution for their health by scheduling an appointment for preventive screenings, which can lead to early detection of health issues and better outcomes.

Health care providers can refer to their Humana-covered patients' Humana Member Summary reports or Humana Stars Quality Reports to find specific gaps in care and then follow up with reminders about needed screenings.

For more information about preventive screenings, health care providers can contact Humana customer service at 1-866-753-8451.

ICD-10 Planning and Training May Prevent Reimbursement Delays

The transition to International Classification of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM) codes on Oct. 1, 2015, will provide the accuracy needed for reimbursement structures based on quality of care and outcomes data. As part of this transition, Humana is working to minimize disruption to health care providers and reduce potential financial impact to revenue.

Humana offers the following information about coding and documentation for reimbursement using ICD-10-CM codes to help health care providers prepare for the transition:

- **Risk adjustment and risk scores**
  One major area of impact for the ICD-10 transition is risk adjustment, which correlates reimbursement to the individual patient's health needs based on health risk. The risk is quantified by a numerical score assigned to diagnosis codes. An individual risk score is then calculated from claims data. Risk adjustment is being applied to an increasing number of programs, most notably health care exchanges and Medicaid plans.

- **Diagnosis codes and hierarchical condition categories (HCC)**
  While each diagnosis receives an individual score, diagnoses are grouped into condition categories. Within these condition categories, the diagnoses are assigned to a hierarchy from which only the highest level diagnosis code within the hierarchical group receives a reportable score. The highest value scores from each category are added together to determine the patient's risk score. These HCCs are used by CMS to structure reimbursement to the MA plans based on an aggregate of all individual scores within the plan.

  HCC reimbursement can be compared to the diagnosis-related-grouping (DRG) system, as both systems calculate payments based on reported diagnosis codes. While DRG reimbursement is for an episode of care, HCC payments are semiannual calculations. The calculation for HCC reimbursement relies heavily on reported diagnoses; therefore, the importance of the shift to ICD-10-CM cannot be overstated.

  Risk-adjusted payment requires very specific documentation of conditions. The selection of relevant conditions to document, and their complete documentation, is crucial to the accurate assignment of diagnosis codes. ICD-10-CM codes provide much more specificity, allowing providers to report conditions with greater detail and accuracy. Although conditions supporting medical necessity for services are still required, there are other conditions that must be considered for risk adjustment. The reporting of chronic conditions, conditions affecting management or treatment of current illness and status conditions (e.g., ostomies, dialysis and amputations) are of significant consequence to the accurate description of the patient's status and the resulting score.

- **Reimbursement**
  Reimbursement methodologies based on reported diagnoses, such as HCC models, will be directly impacted. Theoretically, there should be little to no impact on HCC-related reimbursement if the HCC models are not changed. However, because there is not a one-to-one correlation between ICD-9-CM codes and ICD-10-CM codes, the possibilities exist in which conditions reported by an ICD-9-CM code and grouped into an HCC may be reported by multiple ICD-10-CM codes, resulting in a different HCC grouping for some codes.

  Until CMS publishes the complete and final mapping between ICD-10 codes and the HCC models, the full impact cannot be easily determined. However, the preliminary ICD-10-CM mapping that is currently available on the CMS website (http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Prelim-IDC10Mappings.html?DLPage=1&DLSort=0&DLSortDir=descending) contains very limited variations from current HCC categorizations, especially for primary-care-related diagnoses.

Humana encourages health care providers to complete a documentation review of charts that include their top 10 most-reported diagnoses. This exercise should include recoding the sample charts with ICD-10-CM codes. After ICD-10-CM codes are chosen, the CMS-proposed HCC can be assigned to determine if there are variations and thus, financial impacts to risk-sharing health care providers. Diagnosis codes that map to high-risk values, but may not be reported as frequently as the top 10, also need to be examined.

- **Coding guidelines**
  It is important to note that many of the official coding guidelines remain the same in ICD-10-CM. While the codes may look different, the codes selection process has not significantly changed. It is important that nonfacility health care providers, coding staff, revenue cycle employees and others receive adequate training in the importance and use of the ICD-10-CM Official Guidelines for Coding and Reporting. The training needs to cover a complete study of the official guidelines. Educating staff to be aware of the official guidelines and their application will positively affect the accurate assignment of both diagnosis codes and HCC scores.

  In addition to greater specificity of codes, including laterality and episode of care specification, ICD-10-CM codes provide combination codes for conditions that require multiple ICD-9-CM codes for accurate reporting. Perhaps the most significant examples of ICD-10-CM combination codes that impact the assignment of hierarchical condition categories are the diabetes mellitus codes. Each ICD-10-CM diabetes mellitus code reports the type of diabetes, the type of complication and its specific manifestation. The controlled status of diabetes is no longer a factor in the assignment of a code.

- **Clinical documentation improvement**
  Comprehensive training in clinical documentation improvement and the guidelines for reporting ICD-10-CM codes is crucial to the minimization of negative impacts.

  All references are to the ICD-10-CM and do not include ICD-10-PCS.

ICD-10 resources

Health care providers can find additional ICD-10 information from the following resources:

- Humana's provider website: https://www.humana.com/provider/medical-providers/education/claims/icd-10/
- CMS: www.cms.gov/ICD10
- Workgroup for Electronic Data Interchange (WEDI): www.wedi.org/workgroups/icd-10

ICD-10 questions may be submitted to one of the following Humana mailboxes:

- Facilities: ICD10Inquiries@humana.com
- Physicians: ICD10Physician@humana.com
- Claim delegates: IPAICD10Inquiries@humana.com

CMS Restructures Quality Improvement Organization (QIO) Program

The Centers for Medicare & Medicaid Services (CMS) recently restructured the Quality Improvement Organization (QIO) program to improve patient care and health outcomes, as well as save taxpayer resources. Effective Aug. 1, 2014, the existing QIO contractors were replaced by two Beneficiary and Family-centered Care Quality Improvement Organization (BFCC-QIO) contractors.

The BFCC-QIOs contractors are responsible for conducting quality of care reviews, discharge and termination of service appeals and other areas of required review in various health care provider settings. The two new BFCC-QIOs contractors are Livanta and KePRO.

Livanta will service:

- Area 1
    - Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Virgin Islands
    - Address
      Livanta
      BFCC-QIO Program
      9090 Junction Drive, Suite 10
      Annapolis Junction, MD 20701
        - Toll-free number: 1-866-815-5440 (TTY: 1-866-868-2289)
        - Fax numbers: 1-855-236-2423 (for appeals) or 1-844-420-6671 (for all other reviews)
- Area 5
    - Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington
    - Address:
      Livanta
      BFCC-QIO Program
      9090 Junction Drive, Suite 10
      Annapolis Junction, MD 20701
        - Toll-free number: 1-877-588-1123 (TTY: 1-855-887-6668)
        - Fax numbers: 1-855-694-2929 (for appeals) or 1-844-420-6672 (for all other reviews)

KePRO will service:

- Area 2
    - District of Columbia, Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia (Tampa office)
    - Address:
      KePRO
      5201 W. Kennedy Blvd., Suite 900
      Tampa, FL 33609

    - Toll-free number: 1-844-455-8708
    - Fax number: 1-844-834-7129
- Area 3
    - Alabama, Arkansas, Colorado, Kentucky, Louisiana, Mississippi, Montana, North Dakota, New Mexico, Oklahoma, South Dakota, Tennessee, Texas, Utah, Wyoming (Seven Hills)
    - Address:
      K3PRO
      5700 Lombardo Center Dr., Suite 100
      Seven Hills, OH 44131
        - Toll-free number: 1-844-430-9504
        - Fax number: 1-844-834-7129
- Area 4
    - Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin (Tampa office)
    - Address:
      KePRO
      5201 W. Kennedy Blvd., Suite 900
      Tampa, FL 33609
        - Toll-free number: 1-855-408-8557
        - Fax number: 1-844-834-7130

Health care providers need to update the following notices with the new BFCC-QIO contact information:

- The Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC)
- Important Message from Medicare (IM) (Form CMS-R-193)

More information about the QIO restructuring can be found in the CMS news release at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-05-09.html. Health care providers who have questions about the QIO program can contact the QIO Program mailbox at QIOPrograms@CMS.hhs.gov. For questions related to the notices of non-coverage, contact Part_C_Appeals@cms.hhs.gov.

Physician Bonus Programs Reward Health Care Providers

Each year, Humana sends three different bonus payments to eligible health care providers. The following gives an overview of each type of bonus offered through the Centers for Medicare & Medicaid Services (CMS):

- **Primary Care Incentive Payment Program (PCIP) —** Eligible primary care providers receive a quarterly bonus equal to 10 percent of the Medicare paid amount for eligible primary care services furnished. Humana receives an eligibility listing from CMS and then issues the incentive based on Humana Medicare claims for a specific time frame.

  CMS initiated this incentive in 2011. Primary care providers are paid a percentage of the paid Medicare amount for primary care services furnished by a designated primary care provider. To be considered for this incentive bonus, recipients must practice in one of the following primary care specialties: family medicine, internal medicine, geriatric medicine, pediatric medicine, nurse practitioner, clinical nurse specialists or physician assistant.

  These provider types are eligible for the incentive payment if primary care services for certain Current Procedural Terminology (CPT®) codes accounted for at least 60 percent of the primary care provider's total allowed charges under the physician fee schedule in the qualifying calendar year.

- **Health Professional Shortage Areas (HPSA) Physician Bonus Program —** CMS provides a 10 percent bonus payment to health care providers who furnish Medicare-covered services to beneficiaries in a geographic HPSA. The bonus is paid quarterly and is based on the amount paid for professional services.

  HPSAs are geographic areas, or populations within geographic areas, that lack sufficient health care providers to meet the health care needs of the area or population. HPSAs identify areas of greater need throughout the U.S. so that limited resources can be directed to those areas. Areas are designated as HPSAs by the Health Resources and Services Administration (HRSA) based on census tracts, townships or counties.

  Bonuses are paid based on ZIP codes, not National Provider Identifiers (NPIs). Humana receives a ZIP code file from CMS annually to determine which health care providers are eligible for the bonus.

- **Physician Quality Reporting System (PQRS) —** PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible health care professionals.

  The PQRS incentive program is a voluntary individual reporting program that provides an incentive/bonus payment to identified eligible professionals who satisfactorily report data on quality measures for physician fee schedule services. Humana receives an eligibility listing from CMS annually and then issues the incentive based on the Humana Medicare claims (0.5 percent of the allowed charges) for a given time frame.

- Previously, CMS also awarded an Electronic Prescribing (eRx) Incentive Program. This incentive was awarded to physicians who were paid a percentage of the allowed charges for utilizing an electronic prescribing system for their Medicare patients. This program was canceled by CMS in 2013.

For more information about these programs, including eligibility, criteria and requirements, health care providers may use the following resources:

- Web: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html

- Phone: 1-800-MEDICARE (1-800-633-4227)

DEA Imposes Tighter Regulations for Hydrocodone Combination Products

Effective Oct. 6, 2014, the U.S. Drug Enforcement Administration (DEA) moved hydrocodone combination products (HCPs) from Schedule III to the more restrictive Schedule II. The scheduling change of HCPs from Schedule III to Schedule II will not affect Humana's formulary coverage for 2014 and 2015.

Refills on an existing prescription will be valid only if the original prescription was written before Oct. 6 and is filled before April 8, 2015. However, some pharmacy dispensing software products will not be able to process existing refills as of Oct. 6. Humana encourages health care providers to be prepared to work with pharmacists to supply new prescriptions when necessary. New hydrocodone combination prescriptions issued on Oct. 6 or later must comply with Schedule II regulations.

Health care providers who need more information about the change can call 1-877-222-0589.

Apria to Supply Outpatient Negative Pressure Wound Therapy (NPWT) for Humana Members

Apria now is Humana's national provider of negative pressure wound therapy (NPWT). Apria has a comprehensive selection of NPWT brands and products to meet the therapy needs of Humana members. Other local providers of NPWT are available to Humana members.

Please note that this change affects outpatient NPWT only. It does not affect facilities administering NPWT services while a Humana member has inpatient status. Apria works with Humana case managers to facilitate members' transition to NPWT products in the outpatient setting.

Humana members and health care providers can reach Apria's dedicated phone line at 1-800-780-1228. Assistance is available Monday through Friday, from 7 a.m. to 7 p.m. CST. This number provides access to all NPWT services, including new patient referrals, resupply needs and clinical support.

Health care providers are encouraged to inform office staff, discharge planners and case managers about this change. If practitioners need additional education, training or support regarding NPWT referral to Apria, they may contact Julie Sutton, Apria's vice president of managed care, by calling 1-209-753-8414 or via email at Julie_Sutton@apria.com.

Reminder: Humana Updates Preauthorization and Notification Lists for 2015

On Jan. 26, 2015, Humana will update preauthorization and notification lists for all commercial fully insured plans [e.g., health maintenance organization (HMO), point of service (POS), preferred provider organization (PPO) and

exclusive provider organization (EPO)], Medicaid plans and Medicare Advantage (MA) and dual Medicare-Medicaid plans. Please note that prior authorization, precertification, preadmission, preauthorization and notification are all used to refer to the preauthorization process.

For MA Private Fee-for-Service (PFFS) plans, notification is requested, not required. In addition, certain services outlined in the preauthorization and notification lists may not be applicable for Chicago, Nevada or California health care providers affiliated with an independent physician association (IPA) via a capitated arrangement. Health care providers may refer to their provider agreements for additional information or requirements concerning preauthorization.

Updates to the lists include the following:

- Preauthorization of facility-based sleep studies (PSG) will now be managed by HealthHelp, a benefit management organization.
- Humana asks health care providers to submit claims for Healthcare Common Procedure Coding System (HCPCS) drug codes with the corresponding national drug code (NDC). Beginning Jan. 26, 2015, Humana will reject claims for the following types of drug codes if submitted without an NDC:
    - Shared HCPCS codes
    - Not Otherwise Classified (NOC) codes

The lists are available here (https://www.humana.com/provider/medical-providers/education/claims/pre-authorization). Health care providers also may call the phone number on the back of the member's identification (ID) card to determine if a service requires preauthorization.

Changes Implemented for Participating Insulin Pump Providers

Humana has made changes to its provider network for insulin pumps. Refer to the following chart for Humana's national insulin pump distributor providers:

Provider	**Contact**	In-ntwk for HCP?*	In-ntwk for HMP?**	In-ntwk for HEP?***
CCS Medical	1-877-531-7959	Yes	Yes	Yes
Diabetes Management Services	1-888-738-7929	Yes	Yes	No
Edwards Health Care Services	1-888-344-3434	Yes	Yes	No

* Humana commercial plans

** Humana Medicare plans

***Humana Exchange plans

Humana's agreements with the following insulin pump manufacturers have been terminated:

- Medtronic Minimed (effective July 31, 2014)
- Tandem (effective July 31, 2014)
- Animas (effective Oct. 10, 2014)
- Roche (effective Oct. 31, 2014)
- Insulet (effective Oct. 31, 2014)

These terminations do not impact Humana members' ability to access specific brands of insulin pumps.

Other local providers of insulin pumps are available to Humana members.

Online Tools, Presentations, Webinars Provide Important Tips to Providers, 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 new guidelines adopted. 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 health care providers 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

- No updated Clinical Practice Guidelines this issue

Newly Added Clinical Practice Guidelines

- No newly added Clinical Practice Guidelines this issue

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 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

- Northera (droxidopa)
- Kerydin (tavaborole)
- Striverdi Respimat (olodaterol)

Pharmacy Coverage Policies with Significant Revisions

- No pharmacy coverage policies with significant revisions

New Medical Coverage Policies:

- Drug Testing
- Lung Cancer Screening

Medical Coverage Policies with Significant Revisions:

- Capsule Endoscopy
- Cardiovascular Disease (CVD) Risk Testing (Laboratory)
- Functional Electrical Stimulators (FES), Diaphragmatic/Phrenic Nerve Stimulation
- Multianalyte Assays with Algorithmic Analyses (MAAAs) for Nonmalignant Diseases
- Serological and Fecal Testing for Inflammatory Bowel Disease (IBD)
- Spinal Decompression Surgery

Retired Medical Policies

- No retired medical coverage policies

Online Presentations Make It Easier to do Business with Humana

Humana's "Education on Demand" tool provides health care providers and their office staff members with quick, easy-to-understand presentations on topics that should make it easier for them to do business with Humana.

To access these presentations, health care providers may choose: Humana.com/provider/support/on-demand (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 presentations are as follows:

- Commercial Risk Adjustment
- How to do Business with Humana
- HumanaAccess℠ Card
- RadConsult™ Online
- Texas Deficiency Tool
- Special Needs Plans (SNPs)

The presentations can be accessed around the clock.

Webinars Provide Interactive Learning

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

2014 Provider Webinar Training Schedule

Humana.com Overview
This webinar provides information about Humana.com's self-service tools available for health care providers. Providers can expect to learn more about eligibility and benefits, referrals and authorizations, claims tools, remittance inquiry, fee schedules and more.

- Tues., Jan. 13 at 2 p.m. EST
- Thurs., Feb. 5 at 11 a.m. EST
- Wed., March 11 at 2 p.m. EST

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. Health care providers 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.

- Thurs., Jan. 8 at 11 a.m. EST
- Wed., Feb. 4 at 2 p.m. EST
- Tues., March 10 at 11 a.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 health care providers check the status and make changes to existing referrals and authorization requests.

- Wed., Jan. 7 at 2 p.m. EST

- Tues., Feb. 3 at 11 a.m. EST
- Thurs., March 5 at 2 p.m. EST

Claim Tools and Remittances
This webinar teaches how to reconcile and manage accounts receivable by reviewing claims status, results and remits online. Health care providers will learn how to make corrections to professional claims, send attachments, view and download remittance advice.

- Thurs., Jan. 15 at 11 a.m. EST
- Tues., Feb. 10 at 2 p.m. EST
- Thurs., March 19 at 11 a.m. EST

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)
This webinar includes instruction on how to get payments faster by registering for electronic funds transfer and how to receive electronic remits either through a clearinghouse or Humana.com. The webinar also walks through the registration process.

- Tues., Jan. 20 at 11 a.m. EST
- Thurs., Feb. 12 at 2 p.m. EST
- Tues., March 24 at 11 a.m. EST

Benefit Estimator
This webinar instructs health care providers how to create a real-time estimate of a patient's payment responsibility for professional services. These estimates are specific to each health care provider's Humana provider agreement and the member's benefit plan.

- Thurs., Jan. 22 at 2 p.m. EST
- Tues., Feb. 17 at 11 a.m. EST
- Thurs., March 26 at 2 p.m. EST

Medical records management and resources
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.

- Thurs., Jan. 29 at 11 a.m. EST
- Wed., Feb. 18 at 2 p.m. EST
- Thurs., March 31 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 your 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 your request.