Humana's YourPractice

Provider SmartSummary Wins Best Written Communication Award

Humana is proud to announce that its Provider SmartSummary® (PSS) won THESOURCEAWARDS™ for 2013 in the category of Best Written Communication. THESOURCEAWARDS is a jury-awarded recognition for payer-sponsored and multipayer portals, educational programming, written communications and app/mobile resources. THESOURCEAWARDS documents and promotes best practices in informing, engaging and educating the health care provider audience.

"Humana is honored to receive this award," said Tim McClure, strategic consultant for Humana's provider development center of excellence. "We are committed to, and have a long history of, listening to and working with health care providers to reduce administrative burden and enabling them to focus on providing clinically excellent care. Provider SmartSummary is one example of a Humana tool that facilitates an effective provider-payer relationship," McClure said.

What is Provider SmartSummary?

PSS is a quarterly report of key administrative and clinical metrics for physician groups and hospitals. It includes tips and messages for health care providers to better manage their relationship with Humana. It is accessed by Humana associates who share it with health care providers, as appropriate. At this time, health care providers cannot access the report directly from Humana's website.

In order for a PSS to be produced, a health care provider must have had at least 100 claims processed by Humana under his or her provider tax identification number during the calendar quarter. Due to member attribution logic and claims run-out period, the quarterly PSS lags behind a bit (for example, fourth quarter 2013 reports became available in mid-April).

THESOURCEAWARDS gave Humana's PSS high scores in the following areas:

Content

- Contains well-thought-out high-level quarterly health care provider scorecard with metrics on claims processing and patient care
- Achieves its purpose in providing a Humana relationship summary for each health care provider
- Offers tips and callouts that provide additional guidance in claims processing efficiencies
- Gives meaningful definitions of terminology

Visual Design

- Layout of the information is clear and visually appealing, with details that are simple, yet informative
- Effective use of color for presentation and ease of use

For more information about Provider SmartSummary, health care providers can contact their provider relations representative.

Changing Our Approach to Leadership

Dear Physicians and Office Staff,

At Humana, we are evolving from a traditional insurance company to a health company. This means that consumers are at the core of everything we do. And our definition of "consumer" has evolved as well. Consumers are no longer limited to just members or potential customers, but everyone we serve, including physicians, other health care providers and the Centers for Medicare & Medicaid Services (CMS). Working with health care providers as a consumer gives us the opportunity to engage with them in new ways, like hosting clinical town hall meetings, participating together in accountable care relationships and connecting through our Provider SmartSummary.

That engagement includes an increasing number of clinicians – physicians, nurses, pharmacists and others – who can help us simplify our processes while focusing on quality, data and engagement. Having that clinical viewpoint directly affects our daily decision-making. Health care providers and staff members just like you are helping us pinpoint where patients get the highest quality care for the best value.

I recently spoke with Managed Care Editor John Marcille about Humana's efforts in this interview. I hope you'll take a few minutes to read it and learn more about how we are changing our approaches to quality, accountability and leadership.

It is our mission to facilitate the best, most appropriate care to our members, no matter where they are.

Sincerely,

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

Humana Medicare Members Earn Rewards for Healthy Behaviors

The 2014 Humana Medicare Rewards program incentivizes members to become healthier by receiving preventive screenings and tests throughout the year. Health care providers should be aware that their Humana-covered patients may be coming to them with questions concerning which eligible tests they should get, which may earn rewards.

The Medicare rewards program promotes engagement between members and their health care providers to improve their physical well-being. All reward materials advise the member to create a health care plan with his or her physician, based on the list of rewards-eligible preventive health screenings. Based upon the member's

personal health history and needs, the health care provider should recommend, order and assist the member with obtaining his or her screenings, tests and shots.

The program consists of mailing letters and fliers to Humana Medicare members, encouraging them to get four of the preventive health care activities listed in the rewards program materials. Once the member gets four of the eligible screenings or tests in a calendar year, he or she earns five individual $10 gift cards. The gift cards are redeemable at restaurants, gas stations, movie theaters and stores. Members are able to mix and match the gift cards or pick five from the same company.

Eligible preventive screenings and tests include:

- Flu shot
- Pneumonia vaccine
- Hepatitis B vaccine
- Annual wellness visit
- Bone mass osteoporosis test
- Cardiovascular disease screenings
- Mammogram
- Pap and pelvic exam
- Colorectal cancer screening
- Prostate cancer screening
- Glucose diabetes screenings
- Welcome to Medicare visit
- Alcohol misuse screening
- Behavioral therapy for cardiovascular disease
- Sexually transmitted infection (STI) screening and behavioral counseling
- HIV screening
- Behavioral therapy for obesity
- Depression screening

Health care providers and members are not responsible for contacting Humana about the tests; the rewards will be given based on claims submitted for the eligible screenings. When a member has completed four reward activities, he or she will be sent a reward notice.

HumanaVitality program also rewards members

Many Humana Medicare members participate in the HumanaVitality wellness program, which also includes a reward component. Members with HumanaVitality earn rewards in the form of Vitality Bucks when they receive the

preventive screenings and vaccinations noted above. These Vitality Bucks can then be used to purchase items in the Vitality Mall. Selections include some of the same types of gift cards available in the Humana Rewards program. If a member has HumanaVitality, the HumanaVitality logo will appear on his/her Humana ID card. The list of eligible preventive screenings and vaccinations is the same for both programs, as directed by Medicare. Neither rewards program should be discussed with Medicare beneficiaries who are not yet Humana members.

It is important to note the rewards programs are not available to all Humana members.

For more information on the Medicare Rewards program, health care providers can call 1-800-968-2281, Monday through Friday, 8 a.m. to 11 p.m. EST and Saturday, 8 a.m. to 6:30 p.m.

Provider Payment Integrity Department to Increase Medical Record Prepayment Reviews

Starting this quarter, Humana's Provider Payment Integrity (PPI) department is expanding prepayment medical record reviews to include diagnosis-related-group (DRG) coding validation and short-stay reviews as part of its fraud, waste and abuse program.

A prepayment review allows the health care provider to submit itemized bills, medical records and/or other supporting documentation to Humana that will help determine proper payment.

Prepayment review will help in the following areas:

- Health care providers can verify that their claim's billing and coding is accurate and supported by the medical record.
- Health care providers can confirm that the setting is appropriate.
- The reviews will help decrease requests for post-payment audits.
- Prepayment reviews will help expedite the process when an audit is requested.

Please note: These reviews are recommended for cases that have not already been clinically reviewed and approved by a Humana registered nurse or physician.

How prepayment review works:

- Humana will request medical records to make an initial proper payment determination on claims selected for prepayment review.
- Health care providers will need to send requested documentation within 30 days of the request or within the appropriate federal- or state-mandated guidelines.
- Health care providers can respond to requests by faxing, mailing or uploading medical records to Humana's secure provider website on Humana.com (registration required). Uploading to Humana.com provides immediate confirmation that records were received and allows health care providers to check the status of all requests.

- Following the initial medical records request, health care providers may receive a call from Humana or its designees seeking the requested documentation.
- The review will be completed and the claim processed within five to seven business days of receipt of the requested information.
- If Humana or its designee determines that a coding and/or billing error is applicable that results in a payment reduction, the health care provider will be informed of the findings via letter and Explanation of Remittance.
- If the health care provider disagrees with the adjustment, he or she may follow Humana's PPI appeal process or claims dispute process, whichever is applicable.

In the future, Humana plans to expand prepayment reviews to other programs, such as the hospital bill chart audit.

For questions regarding the above information, please contact provider payment integrity customer service at 1-800-438-7885. Additionally, health care providers can find more information at the following website: https://www.humana.com/provider/medical-providers/education/claims/financial-recovery/.

Use E-prescribing to Determine Formulary Coverage

Health care providers may be seeing many new patients with Humana coverage through the health insurance marketplace. Determining which formulary coverage these members have can be challenging. E-prescribing can be a helpful tool for determining formulary coverage.

Electronic prescribing, or e-prescribing, is the electronic transmission of a medical prescription between the point of care and the dispenser. E-prescribing allows a health care provider to electronically transmit a new prescription or renewal authorization to a local or mail-order pharmacy.

How e-prescribing can help determine formulary coverage information:

- Dr. Smith logs into her e-prescribing software
- Dr. Smith selects Sally, her 10 a.m. appointment
- The software performs an eligibility check and determines that Sally is a Humana member assigned to Formulary A
- Dr. Smith prescribes Aricept for Sally
- The software receives formulary-specific information for Aricept, including formulary status, cost-share information, formulary alternatives and drug-specific messaging
- An on-screen display of the formulary-specific information for Aricept is presented to Dr. Smith

Along with helping to determine a Humana member's formulary coverage information, e-prescribing can help reduce medication errors and increase patient safety. Additionally, e-prescribing may improve efficiency and consumer convenience.

E-prescribing gives the prescriber access to real-time patient information, including:

- Patient pharmacy benefit eligibility and coverage
- Plan
- Formulary for the patient
- Medication history
- Drug-to-drug interactions and allergies

E-prescribing may help prevent medication errors by allowing each prescription to be electronically checked at the time of prescribing for dosage, interactions with other medications and therapeutic duplication. E-prescribing could potentially improve quality and efficiency and reduce costs by:

- Promoting appropriate drug usage, such as following a medication regimen for a specific condition
- Providing information about formulary-based drug coverage, including formulary alternatives and copayment information
- Speeding up the process of refilling medications

For more information about e-prescribing, health care providers can contact Humana customer service at 1-800-4-HUMANA (1-800-448-6262).

Humana Expands Oncology Quality Management Program

Humana is expanding its Oncology Quality Management (OQM) program. The OQM program will be available nationwide by the end of 2014. The OQM program's aim is to provide Humana members with access to cancer care that is supported by the strongest medical evidence and expert consensus. The program is a quality-focused collaboration with two national vendors: Oncology Analytics and New Century Health. OQM encourages the use of evidence-based guidelines in chemotherapy and works to improve the health care provider experience by reducing administrative burden and offering consultation-based peer-to-peer capabilities. Other benefits offered by the program include:

- Web-based prior authorization
- Medical oncology board-certified panels
- More timely referrals to Humana clinical support programs
- Information that is tailored for each health care provider
- Incentive program for health care providers to follow established protocols.

New Century Health

New Century Health, an oncology and cardiology specialty care management organization, and Humana began working together in 2004. New Century's services, such as a prior-authorization platform and specialist-to-

specialist physician consultation, enable patients, payers and physicians to benefit from the selection of evidence-based, cost-effective therapies.

Currently, New Century Health is available in the following markets:

Alabama, Alaska, Arizona, Colorado, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Missouri, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Utah, Wisconsin, Virginia, Washington, West Virginia and Wyoming.

Upcoming New Century Health Markets

June 2014: California, Hawaii, Mississippi and Nevada

July 2014: Arkansas, New Mexico and Oklahoma

August 2014: Iowa, Montana, Nebraska, North Dakota and South Dakota

Oncology Analytics

Oncology Analytics (OA) is accredited by the Utilization Review Accreditation Commission (URAC) and offers clinical decision-support expertise to health care providers. OA's services focus on improving clinical efficacy, reducing toxicity and verifying reasonable costs. OA creates value through its proprietary software, a database of more than 1,300 treatment protocols, a patented reimbursement system and clinically rigorous decision support.

Oncology Analytics is currently available in the Florida, Georgia and Texas markets.

Upcoming Oncology Analytics Markets

August 2014: Delaware, Massachusetts, New Hampshire, New Jersey and Vermont

September 2014: Pennsylvania and Maryland

October 2014: Connecticut, New York and Rhode Island

For more information about the Oncology Quality Management program, health care providers can call Sabina Sisic-Morris at 502-580-5828.

Humana Outreach Efforts can Help Patients Receive Recommended Care

The clinical Healthcare Effectiveness Data and Information Set (HEDIS) Star measures are important, not only to health plans, but to individual health care providers as well. The Star measures focus on preventive care that can help patients stay healthy and catch health problems before they become serious. Physicians can help meet the Star-HEDIS goals by encouraging their patients to receive necessary tests and/or screenings and submitting appropriately coded claims/encounter data for each service rendered.

Humana regularly reaches out to members to raise their awareness about needed medical tests and screenings, using a variety of communication channels. Members get reminders about addressing gaps in care, informing them about screenings and tests they need to complete before the end of the year. Women receive messages encouraging them to have a breast cancer screening.

Humana uses posts on its Facebook and Twitter accounts to share information about the importance of screenings, as well. Members are encouraged to visit their primary care physicians (PCPs) and discuss with them the importance of preventive tests and screenings.

Heath care providers receive Star Quality Reports (SQR) throughout the year. The SQR identifies their Humana-covered patients who have open gaps in care that need to be addressed in 2014. It also includes instructions on how health care providers can close the care gaps and where to send the information once the care caps are closed.

For more information about the clinical Star-HEDIS measures, health care providers can visit the Quality Resources page on **Humana.com/providers** (https://www.humana.com/provider/support/clinical/quality-resources). Scroll down to find detailed information about individual Star measures, including pertinent coding information.

Take Steps to Determine ICD-10 Transition Readiness

Although the ICD-10 transition deadline has been postponed and compliance will not be enforced before October 2015, physician and medical coder training should begin now to help facilitate a smooth transition to ICD-10. Health care providers should consider the following when determining their practices' readiness for the transition to ICD-10:

Has the practice budgeted for the costs associated with implementing ICD-10?
If a practice has not prepared a budget or spent time and money for staff training, it may not be ready for the transition to ICD-10.

It is vital to financially plan for ICD-10. Health care providers should work with software vendors to help plan the costs associated in getting their practice ready for ICD-10 transition. Planning ahead will help to mitigate risks and help alleviate any disruption to a health care provider's claims management process. Also, health care providers may want to include a cash reserve to offset any unforeseeable risks.

Areas of focus when preparing a budget for ICD-10 include the following:

- Information systems
    - Hardware upgrades
    - Software updates or purchases
- Documentation audits
- Education and training
- Staffing

Is the practice working with a software vendor?
Some software vendors may indicate that they will get a practice ready for the ICD-10 transition; however, they may not specify the additional steps necessary to ensure readiness. Health care providers should take the time to research professional organizations for examples of the ICD-9 to ICD-10 mappings that are available in addition to what a software vendor may provide. Also, health care providers should identify what codes their practices use

most often and what risk categories may greatly impact their practices. Humana recommends that health care providers check that their software vendor has been certified as ICD-10 ready by national accreditation/certification organizations.

How should a practice handle the "unspecified code" category?
Many health care providers may be selecting unspecified codes on a regular basis. When using ICD-10 codes, this may not be the best option to receive an accurate payment for the services administered. Health care providers may want to look at the specialty guides offered by the American Academy of Professional Coders (AAPC) to help identify classifications for a specialty practice. The guides are available from the AAPC (http://www.aapc.com/ICD-10/icd-10-reference-guides.aspx) website.

Is the practice ready for ICD-10?
Health care providers can find more information about readiness from the American Medical Association (http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/transaction-code-set-standards/icd10-code-set.page). For more information on ICD-10, health care providers can visit the following websites:

Centers for Medicare & Medicaid Services (CMS)
(http://www.cms.gov/Medicare/Coding/ICD10/Index.html)

Workgroup for Electronic Data Interchange (WEDI)
(http://www.wedi.org/workgroups/icd-10)

Humana
(https://www.humana.com/provider/medical-providers/education/claims/icd-10/)

Health Assessments Promote Preventive Care

Humana's health and well-being focus encourages preventive care and wellness as an important part of healthier living. With the recent influx of members entering the health care delivery system through the health insurance marketplace, the relationship between a patient and his or her primary care physician (PCP) is key to establishing optimum health and wellness. To support this focus on wellness and to help foster the patient-PCP relationship, Humana is offering no-cost assessments to Humana members with individual and small group Affordable Care Act (ACA) coverage.

The goal of the health assessment is to gather more information about the member's health status, enabling the PCP and the member to work together to manage the patient's health. The assessment does not replace the member's annual exam with his or her PCP; however, it is an additional evaluation to help maintain health and well-being.

Humana recently teamed up with Matrix Medical Network and CVS MinuteClinic® to provide health assessments for commercial members in the following states:

Matrix Medical Network	Arizona, Georgia, Ohio and Texas
CVS MinuteClinic	Arizona, Florida, Georgia, Illinois, Kansas (Johnson County), Louisiana, Michigan, Ohio, Tennessee and Texas

Following are some frequently asked questions and answers about the health assessment:

1. **Q: Why is Humana offering health assessments?**
   A: The health assessments are meant to provide an up-to-date review of the member's current health status. The findings from the health assessment are then shared with the member's PCP so that he/she can coordinate care. In addition, the health assessment helps identify members who may benefit from other Humana clinical programs.

2. **Q: How do health assessments affect health care providers?**
   A: Health care providers who serve Humana commercial members in the specified markets may have a patient invited to participate in a health assessment this year. These members may reach out to their health care providers for more information or with questions about the assessment.

   The health assessment is voluntary and not meant to replace the services members receive from their health care providers. This helps support Humana's and health care providers' mutual focus on providing patients with care and services that meet their unique needs.

3. **Q: How does the Matrix in-home health assessment work?**
   A: Eligible members will receive a letter and brochure about the service. A Matrix Medical Network representative will then call the member to schedule an hour-long health evaluation performed by a licensed nurse practitioner (NP) in the comfort of the member's home. During that visit, the NP asks a series of questions about the member's health and conducts a thorough but noninvasive exam. The findings are then provided to the member's primary health care provider. Please note: If the NP finds something clinically unstable, he or she will call the primary health care provider's office that same day.

4. **Q: How does the CVS MinuteClinic Complete Health Review* assessment work?**
   A: Eligible members will receive a letter inviting them to call and schedule an appointment for a no-cost health assessment. A MinuteClinic family nurse practitioner will provide immediate results, answer the member's questions and offer advice on ways to stay healthy. The visit summaries are sent to the member's PCP upon verbal consent. The Complete Health Review at the MinuteClinic includes health assessment and physical exam, medication review, blood pressure check, blood sugar test and lipid profile.

   ***Complete Health Review is MinuteClinic's name for the package of services outlined above and is not meant to replace the members' annual exam with his or her PCP.**

5. **Q: What are the benefits of the health assessment?**
   A: Members benefit from the health assessment in several ways:

   - Quick health assessment, without having to wait to make an appointment with a PCP
   - Better coordination of care is achieved when information from the assessment is shared with the member's primary health care provider, and the NP helps coordinate patient appointments with PCP for urgent care needs
   - Education is provided to each member about how to effectively address health concerns he or she may have

- Complete picture of the member's health to help the member understand how to make informed decisions for healthier living

For more information, contact Humana Provider Relations at 1-800-4-HUMANA (1-800-448-6262), Monday through Friday, 8 a.m. to 6 p.m. local time.

Refer to Guidelines for Working with Dual-eligible Members

The Centers for Medicare & Medicaid Services (CMS) requires that all Medicare Advantage organizations (MAOs) inform their network health care providers about Medicare and Medicaid benefits and rules for enrollees (members) eligible for both Medicare and Medicaid (i.e., dual eligible).

The following information provides an overview of the general eligibility and cost-sharing guidelines for Medicaid coverage of dual-eligible members.

Who are Dual-eligible Members?

Original Medicare beneficiaries who have limited income and resources may get help paying for their Medicare premiums and out-of-pocket medical expenses from Medicaid. Medicaid may also cover additional services beyond those provided under Medicare. Individuals entitled to Medicare Part A and/or Part B and who are also eligible for some form of Medicaid benefit are referred to as dual-eligible members.

Dual-eligible Beneficiary Categories

Dual-eligible beneficiary categories are based on Medicare eligibility, Medicaid eligibility and income levels. The table below offers further explanation of these categories.

Dual Eligible Category	Description	Medicare Part A Criteria	Benefits
QMB Only*	Qualified Medicare Beneficiary without other Medicaid	Entitled to	Eligible for Medicaid payment of Medicare premium, deductible, coinsurance and copayment amounts (except for Medicare Part D).
QMB Plus**	Qualified Medicare Beneficiary with Comprehensive Medicaid Benefits	Entitled to	Entitled to all benefits available to a QMB, as well as all benefits available under the State Medicaid plan.

Dual Eligible Category	Description	Medicare Part A Criteria	Benefits
SLMB Only*	Specified Low-Medicare Beneficiary with Comprehensive Medicaid Benefits	Entitled to	Entitled to all benefits available to a SLMB, as well as all benefits available under the State Medicaid plan.
SLMB Plus**	Specified Low-Medicare Beneficiary with Comprehensive Medicaid Benefits	Entitled to	Entitled to all benefits available to a SLMB, as well as all benefits available under the State Medicaid plan.
QI	Qualifying Individual	Entitled to	Eligible for payment of Medicare Part B premiums only; however, expenditures are 100% federally funded and total expenditures are limited by statute.
QDWI	Qualified and Disabled Working Individual	Lost Benefits due to returning to work, but is eligible to enroll in and purchase	Eligible for Medicaid payment of Medicare Part A premiums only.
FBDE	Other Full Benefit Dual Eligible	Entitled to	Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers

*** These beneficiaries do not qualify for any additional Medicaid benefits**

**** These beneficiaries often qualify for full Medicaid benefits by meeting the Medically Necessary standards or through spending down excess income to the Medically Needy Level.**

Medicare Advantage (MA) Plans and Dual-eligible Members

MAOs must also follow the same guidelines as Original Medicare for members who are dual eligible and confirm that:

- Members will not be held liable for Medicare Part A and B cost-sharing when the member's state is responsible for paying such amounts.
- Member cost-sharing does not exceed the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan.

MAO providers must:

- Accept the MA plan payment as payment in full, or
- Bill the appropriate state source.

The Social Security Act provides that Medicare pay first for all services provided to dual-eligible beneficiaries. Additionally, the enrollee's state may limit Medicaid payment, including nominal costs-sharing amounts as permitted under the act and specified in the state Medicaid plan.

Cost-share for members enrolled in an MA plan may include:

- Coinsurance and/or copayment
- Deductibles
- Premiums

The following table identifies the cost-share that can be collected from dual-eligible members based on the member's dual-eligible beneficiary category.

Dual Eligible Beneficiary Category	Full Medicaid	Part C Premium for Basic Medicare Part A and Part B Benefits and Mandatory Supplemental Benefits	Part C Premium for Optional Supplemental Benefits	Part C Medicare Deductible, Coinsurance, and Copayment
QMB Only*	No	Optional	Not Allowed	Required
QMB Plus**	Yes	Optional	Optional	Required
SLMB Only*	No	Not Allowed	Not Allowed	Not Allowed
SLMB Plus**	Yes	Not Allowed	Optional	Conditional
QI	No	Not Allowed	Not Allowed	Not Allowed
QDWI	No	Not Allowed	Not Allowed	Not Allowed
FBDE	Yes	Not Allowed	Optional	Conditional

*** These beneficiaries do not qualify for any additional Medicaid benefits**

**** These beneficiaries often qualify for full Medicaid benefits by meeting the Medically Necessary standards or through spending down excess income to the Medically Needy Level.**

***** QMBs, SLMBs and QIs are automatically enrolled in the low-income stub side program and are, therefore, not subject to Medicare Part D premium.**

For more information about dual-eligible members, health care providers can call Humana Provider Relations at 1-800-626-2741 from 8 a.m. to 6 p.m., Monday through Friday.

Humana Makes Changes to Home Medical Equipment Provider Network

Humana is changing its preferred home medical equipment provider of outpatient negative wound pressure therapy (NPWT) and supplies to Apria Healthcare. Impacted Humana members will be informed of this change.

Humana has established a long-term relationship with Apria Healthcare, making Apria our provider of choice for Humana members' home medical equipment needs, including NPWT, home oxygen services, CPAP/BiPAP equipment and supplies and other medical equipment services provided in the home.

Apria has more than 2,000 clinicians on staff, as well as disease-specific and therapy-specific clinical patient management programs. Apria also has established quality programs and implements additional services specifically for Humana members.

How this affects health care providers

Humana encourages health care providers to refer Humana-covered patients who need outpatient NPWT and supplies to Apria Healthcare by calling 1-800-780-1228. Humana-covered patients who use Apria for these services and supplies will typically have lower out-of-pocket costs.

For more information about Apria Healthcare, health care providers can visit http://www.apria.com/.

DME Rental or Purchase Rate Coverage Clarified for Capped Rental and Inexpensive Items

Humana would like to remind health care providers about its durable medical equipment (DME) policies for Medicare Advantage (MA) and commercial plans. When determining whether to allow the rental or purchase rate for a charge for durable medical equipment (DME) for members with these plans, Humana generally follows Centers for Medicare & Medicaid Services (CMS) rules. However, if the rate is below a certain threshold, Humana may choose to allow the purchase rate (or, for a unit for which rental has previously been allowed, to allow the balance of the purchase rate) of a DME item for which rental would otherwise be appropriate.

How this might work

In the following examples, the purchase rate is $75, and the monthly rental rate is $20 for a particular item of "Inexpensive or Other Routinely Purchased DME," as defined by CMS.

Example 1

Humana will normally allow $20 each month, until a total of $75 is reached. No additional rental charges are allowed because the full purchase rate has been allowed. The item is purchased.

	Jan	Feb	Mar	Apr	May
Balance owed	$75	$55	$35	$15	$0
Rental allowed	$20	$20	$20	$15	No rental charges are allowed
Remaining balance	$55	$35	$15	$0	

Example 2
Humana may choose to allow the remaining balance of the purchase rate at any time during the rental of the unit. For example, after allowing $20 for the January rental, Humana may choose to allow the full remaining balance of $55 in February. In this example, no additional rental charges will be allowed after February because the full purchase rate has been allowed. The item is purchased.

	Jan	Feb	Mar
Balance owed	$75	$55	$0
Rental allowed	$20	$55	No additional rental charges allowed
Remaining balance	$55	$0	

This reminder applies to both Capped Rental DME items and Inexpensive or Other Routinely Purchased DME items, as defined by CMS. Additional exceptions may apply for some group health plans.

For more information about DME charges, health care providers can visit the following Web pages:

- DME Inexpensive/Other Routinely Purchased policy (http://apps.humana.com/marketing/documents.asp?file=2088463)
- Durable Medical Equipment (DME) Capped Rental policy (http://apps.humana.com/marketing/documents.asp?file=2088450)

Health care providers can also call Humana at 1-800-457-4708 from 8 a.m. to 6 p.m. local time.

New and Expanded Preauthorization and Notification Lists Available Online

To support the expansion of Humana Medicaid and Medicare-Medicaid products in new markets, such as Illinois, Virginia and Florida, new preauthorization and notification lists have been posted to the provider website on **Humana.com** (https://www.humana.com/provider/medical-providers/education/claims/pre-authorization).

These lists make it easier for health care providers to locate the services and medications that require preauthorization or request notification for Medicaid and dual-eligible members.

Health care providers may contact Humana online or via telephone for preauthorization requests or notification submissions. They may use the secure area of Humana's website at **Humana.com/providers** (registration required) or Availity.com (registration required). Alternatively, they can call the interactive voice response (IVR) line at 1-800-523-0023.

Important Notes:
Failure to obtain preauthorization for a service or medication listed could result in denial of claims and payment reductions for the health care provider and reduced benefits for the member, based on the health care provider's contract and the member's Certificate or Evidence of Coverage. Additionally, services or medications provided without preauthorization may be subject to retrospective medical necessity review.

There are exceptions to these lists. Not all procedures and medications are covered by all health plans. Since a single document cannot reflect all possible exceptions, we recommend that an individual practitioner making a specific request for services or medications verify benefits and authorization requirements with Humana prior to providing services.

Health care providers with questions may contact a Humana customer care representative at 1-800-4HUMANA (1-800-448-6262).

Mandatory Compliance Training and Certification Due for All Health Care Providers

The Centers for Medicare & Medicaid Services (CMS) requires that all Humana business partners, including health care providers, complete compliance training and certifications, including reviewing the following materials:

- Compliance Policy for Health Care Providers and Business Partners
- Principles of Business Ethics for Health Care Providers and Business Partners
- General Compliance and Fraud, Waste and Abuse Training
- Special Needs Plan (SNP) training (if your organization has health care providers participating in any Humana Medicare HMO network in one of the following states and/or territories: Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kentucky, Louisiana, Maine, Mississippi, Missouri, New York, North Carolina, Ohio, South Carolina, Tennessee, Texas, Virginia, Washington and Puerto Rico)

Health care providers contracted to support Humana Medicare Advantage can confirm their receipt and understanding of these materials online. This confirmation helps meet health care providers' contractual obligation to comply with state and federal law and Humana's policies and procedures. 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. For more information on how to complete the required compliance certification, refer to this article (http://www3.humana.com/providers/

newsletters/HumanaWeb_02_Feb_2014/articles/CoverStoryOne.html) from the February 2014 edition of Humana's YourPractice.

For additional information about this requirement, refer to these frequently asked questions and answers (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 health care provider suspects or becomes aware of potential noncompliance and/or fraud, waste and abuse, he or she should report it immediately using 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.

Code-editing Software Updated for Professional (Nonfacility) and Facility Claims

As part of Humana's ongoing efforts toward claims process improvements, it periodically updates its claims payment systems to better align with correct-coding initiatives, Centers for Medicare & Medicaid Services (CMS) guidelines, national benchmarks and industry standards. These updates may affect all participating professional health care providers (nonfacility), as well as outpatient facilities and ambulatory surgical centers (ASCs). The policy updates may also affect inpatient facilities. Affected audiences are indicated on the charts posted on **Humana.com**. These changes will occur via a phased approach with implementations and Web postings on the following dates:

Implementation dates	Dates available to view on Humana.com
June 21, 2014	March 21, 2014
Sept. 13, 2014	June 13, 2014
Nov. 8, 2014	Aug. 8, 2014

These and all previously published changes are posted on the health care provider section of **Humana.com** (https://www.humana.com/provider/medical-providers/education/claims/processing-edits) and may be applied to health care providers' claims.

California health care providers please note:
These updates do not affect any contractual relationship California health care providers may have with a contracted independent practice association (IPA). These updates solely pertain to their participation with Humana under their ChoiceCare® Network contract.

A detailed list of the changes will be available on the health care provider section of **Humana.com** (https://www.humana.com/provider/medical-providers/education/claims/processing-edits) 90 days prior to the implementation date as indicated in the above grid.

Humana updates its claim payment systems (primarily those claims submitted on a CMS-1500 form) to better align with American Medical Association (AMA) Current Procedural Terminology (CPT®) code sets, Healthcare Common Procedure Coding System (HCPCS) code sets, International Classification of Diseases, 9th Edition/Revision (ICD-9) code sets and CMS guidelines.

Health care providers who would like additional information about the code-editing changes may submit their question(s) via the "Code Editing Questions" application on the secure health care provider area of Humana's website, **Humana.com/provider**s, by following these steps:

- On **Humana.com/providers**, select "Sign In"
- Enter your user ID and password and select "Sign In"
- Choose the "Claims Tools" tab
- Select "Code Editing Questions" under "Associated Links" to submit your question(s)

In order to access the "Code Editing Questions" application, health care providers must be registered on Humana's website. If a health care provider hasn't registered, he or she should follow these instructions:

1. Go to **Humana.com/providers**, and select "Register"
2. Select "Provider" on the "Please tell us who you are" screen to start the provider registration process
3. Follow the instructions on each page as you move through the application process

Once the registration process is complete, the health care provider will be able to access "Code Editing Questions" and submit questions on the secure provider area of **Humana.com/providers**.

If a health care provider does not have access to the Web and has questions about this information or requires a printed copy of the claims payment changes, he or she may contact a Humana customer care representative at 1-800-4HUMANA (1-800-448-6262), 8 a.m. to 6 p.m. local time, Monday through Friday.

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** (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

- Anoro Ellipta
- Aptiom
- Otrexup
- Vimzim
- Zohydro

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:

- Benign Prostatic Hyperplasia (BPH) Treatment
- Bone Growth Stimulators
- Genetic Testing and Genetic Counseling for Cardiac Conditions
- Home Prothrombin Time (PT) Monitoring Devices
- Intensity Modulated Radiation Therapy (IMRT)
- Pharmacogenomics
- Prophylactic Mastectomy
- Transcatheter Valve Implantation

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** 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.

- Wed., July 16 at 2 p.m. EST

- Thurs., Aug. 14 at 11 a.m. EST
- Tues., Sept. 16 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., July 10 at 11 a.m. EST
- Tues., Aug. 12 at 2 p.m. EST
- Wed., Sept. 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.

- Tues., July 8 at 2 p.m. EST
- Wed., Aug. 6 at 11 a.m. EST
- Thurs., Sept. 4 at 2 p.m. EST

Claim Tools and Remits
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.

- Tues., July 22 at 11 a.m. EST
- Wed., Aug. 20 at 2 p.m. EST
- Thurs., Sept. 18 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.

- Thurs., July 24 at 11 a.m. EST
- Tues., Aug. 26 at 2 p.m. EST
- Thurs., Sept. 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.

- Wed., July 30 at 2 p.m. EST
- Thurs., Aug. 28 at 11 a.m. EST
- Tues., Sept. 30 at 2 p.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: 12/20/13)

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.