HUMANA'S YourPractice

Humana Health Insurance Marketplace Plans Coming in 2014

Dear physicians and office staff:

As consumers prepare for 2014 health care reform changes, Humana encourages health care providers to educate themselves. Major provisions of the Affordable Care Act (ACA) become effective in 2014, including the requirement that nearly all Americans have health insurance coverage or face a tax penalty.

This month, I'd like to talk about one of those major provisions, Health Insurance Marketplaces. Humana expects to participate in the individual Health Insurance Marketplaces in 14 states.

Health Insurance Marketplaces are being established by many states as a part of ACA. They will enable individuals and small groups to purchase insurance that is required by the law beginning Jan. 1, 2014.

Humana's products sold on the Health Insurance Marketplace will include primarily HMO offerings, as we feel this product will provide cost-effective value for both consumers and Humana. For those health care providers who participate with these plans, called HMOx, we are encouraging them to pay close attention to members' ID cards.

Important HMOx Information

HMOx plans require a referral from the member's primary care physician (PCP). We've circled where to look for the plan name and the PCP on the sample ID card. All Humana HMOx members will need to select a PCP who will serve in a care-coordination capacity. Members will be advised that their PCPs are responsible for their care and will refer them for specialty care as needed. PCPs should evaluate and treat their patients with Humana HMOx coverage for all conditions within the scope of their practice, initiate authorizations when needed and communicate with the specialist regarding the nature of the consultation. Specialists will need to contact the referring PCP for referral updates.

Referrals may be made online or via Humana's Interactive Voice Response telephone line.

To submit online: Health care providers may initiate a referral request via Humana's provider website, Humana.com/providers (registration required), or Availity.com (registration required). Once logged into Humana.com/providers, choose "Referral & Authorization Submission" to begin the referral submission process. If your practice uses Availity.com, enter your user ID and password and choose "Log In." Choose "Auths and Referrals," then "Referrals" to begin the referral submission process.

To submit via telephone: Call 1-800-523-0023 and follow the prompts to submit your referral request.

To learn more about Humana's online tools that make submitting referrals easier and faster, register to attend an upcoming webinar (https://www.humana.com/provider/medical-providers/education/provider-self-service/interactive).

More Details for Your Patients with Questions

We recently launched Healthcare For You (http://www.humana.com/healthcareforyou), a website where consumers can get more information about health care reform and the Health Insurance Marketplace.

More Details for You

To learn more about health care reform, health care providers may want to contact professional organizations or advocacy groups, such as the American Medical Association.

If you have questions or need more information about Humana's HMOx plans, please contact us by calling 1-800-626-2741, Monday through Friday, 8 a.m. to 5 p.m. CST.

Sincerely,

Chief Medical Officer
Humana Health Guidance Organization

Make Note of New CMS Billing Requirements for Home Health

Effective with dates of service of Dec. 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will begin rejecting home health encounter claims that do not conform to Medicare billing guidelines. To accommodate this new requirement, all home health claims submitted to Humana for Humana Medicare Advantage members must be coded according to Medicare guidelines.

Overview of standard Medicare home health billing guidelines (not an all-inclusive list):

- Claim must include the appropriate health insurance prospective payment system (HIPPS) code (submitted with Rev 023)

- Claim must include a treatment authorization code (TAC) obtained through Medicare's Outcome and Assessment Information Set (OASIS) system
- Claim must include the core-based statistical area (CBSA) where services were rendered (submitted with Value Code 61)
- Claim must be submitted with an appropriate home health prospective payment system (PPS) bill type
- Each visit must be billed on a separate claim line
- Each visit must be billed with the appropriate Medicare-designated revenue and Healthcare Common Procedure Coding System (HCPCS) codes
- Units billed must be appropriate for the description of the HCPCS code; Medicare visit G-codes represent 15-minute increments of service

---

Humana Updates Preauthorization and Notification Lists for 2014

On Jan. 18, 2014, Humana will implement an updated preauthorization and notification list 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)]. An updated preauthorization and notification list for Medicare Advantage (MA) plans will also be effective. 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:

- Addition of outpatient coronary angioplasty/stent procedures and outpatient transthoracic echocardioplasty (TTE) to the MA preauthorization and notification list
- Expansion of Humana's Oncology Quality Management Program to additional states
- Clarification of substance abuse in the "Mental Heath" category on both the commercial and MA preauthorization and notification lists
- Additions to the medication preauthorization list on both the commercial and MA preauthorization and notification lists

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

Important Notes

- Commercial HMO members: The full list of commercial preauthorization requirements applies to Humana commercial HMO members.
- Humana MA HMO members: The full list of Medicare preauthorization requirements applies to Humana MA HMO members. For MA HMO plans in Florida, specialists should direct all service and medication administration preauthorization requests to the member's primary care physician for referral issuance.
- Humana MA PPO members: The full list of Medicare preauthorization requirements applies to Humana MA PPO members.
- Humana MA PFFS members: For Humana MA PFFS members, notification is requested, but not required, so that members may be referred to appropriate case management and disease management programs. For procedures or services that are investigational, experimental or may have limited benefit coverage, or for questions regarding whether Humana will pay for a service, health care providers may request an advanced coverage determination (ACD) on behalf of the member prior to providing the service. Health care providers may be contacted if additional information is needed.

  ACDs for PFFS members may be initiated by submitting a written request to the following address: Humana Correspondence, P.O. Box 14601, Lexington, KY 40512-4601
- Administrative Services Only (ASO) groups: It is important to note that some employer groups for which Humana provides administrative services only (self-insured, employer-sponsored programs) may customize their plans with different requirements.

Failure to obtain preauthorization for a service or listed medication could result in denial of claims and financial penalties for the health care provider and the member, based on the provider's contract and the member's certificate or evidence of coverage. If a health care provider doesn't obtain authorization for a service indicated on the updated preauthorization and notification list, the claim may be subject to retrospective medical necessity review and may not be paid if it is determined not to be medically necessary. If a provider does not request preauthorization, but the service or medication is considered medically necessary, then the provider or the member may be assessed the preauthorization penalty described in the provider's contract or the member's certificate or evidence of coverage. An authorization does not guarantee payment, and any payment or coverage determination will be based upon all of the provisions of the member's certificate or evidence of coverage (benefit plan document), which is in effect at the time a service is performed.

Humana recommends that an individual practitioner making a specific request for services or medications verify benefits and authorization requirements before providing services.

For more information, contact Humana Customer Service at 1-800-4HUMANA (1-800-448-6262).

Humana Announces Changes to 2014 Formularies

Beginning Jan. 1, 2014, certain drugs will have new limitations or will require utilization management under the Humana commercial and Medicare formularies for the 2013 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 2014 [i.e., prior authorization (PA) requirements, step therapy (ST) modifications and nonformulary (NF) changes]. Humana members are asked to talk to their health care provider about possible alternatives.

Commercial Formulary Changes: View a list of some commonly used medications (http://apps.humana.com/marketing/documents.asp?file=2266251) that will be impacted by Humana commercial formulary changes in 2014 [i.e., 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 www.humana.com/providers/pharmacy/drug_list.aspx. 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 some commonly used medications (http://apps.humana.com/marketing/documents.asp?file=2266264) that will be impacted by Humana Medicare formulary changes in 2014 [i.e., 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 www.humana.com/providers/pharmacy/drug_list.aspx. 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 some commonly used HRMs (http://apps.humana.com/marketing/documents.asp?file=2266277) that will be impacted by Humana Medicare formulary changes in 2014.

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.

“Get Smart About Antibiotics Week” Coming in November

The Centers for Disease Control and Prevention (CDC) will observe its annual Get Smart About Antibiotics Week Nov. 18–24, 2013. This is a great opportunity for health care providers to focus on ways to help stem the widespread problem of antibiotics overuse.

During influenza and cold season, health care providers see many patients who request antibiotics. Each year, tens of millions of antibiotics are prescribed unnecessarily for viral upper respiratory infections. Other common conditions that do not normally require antibiotic therapy are ear infections (except for recurrent otitis media or infection lasting longer than 7 days) and sinus infections.

In states where there is higher antibiotic use, there are more antibiotic-resistant pneumococcal infections. Antibiotic use in primary care is associated with antibiotic resistance at the individual patient level.

Antibiotic-resistant bacterial infections are an increasingly common issue in health care settings and adversely affect the health of millions of people every year. According to the CDC, almost half of the patients who receive prescribed antibiotics are receiving unnecessary therapy, which creates antibiotic resistance.

Antibiotic resistance happens when bacteria change in a way that lessens the effectiveness of the drugs. The problem is growing as many bacteria are now resistant to more than one type of antibiotic. The situation is serious and can lead to a number of complications for patients, such as:

- Greater risk of hospitalization
- Longer hospital stays
- Higher hospital costs
- Increased likelihood of transfer to the intensive care unit
- Higher risk of death

The following suggestions may help reduce the overuse of antibiotics:

- Do not prescribe antibiotics for a viral infection, even if a patient asks for them.
- Prescribe antibiotics only when absolutely necessary and only when it is likely to have a clear benefit – using the appropriate dose for only as long as the antibiotic is needed.
- Avoid unnecessary overlaps in antibiotics. Two antibiotics are not usually needed to treat the same bacteria.
- Use symptomatic relief (over-the-counter medications, ibuprofen, lozenges, nasal decongestants, antipyretics, etc.) to treat likely viral conditions (sore throat, common cold, cough, sinusitis, ear infections)
- Use first-line, narrow-spectrum agents, such as penicillin and amoxicillin, when an antibiotic is appropriate. Refer to the CDC website for resistance patterns of typical causative pathogens when making an antibiotic selection.

It is also important for health care providers to talk to patients about the appropriate use of antibiotics. The health care provider should emphasize that the patient needs to take the antibiotics exactly as directed and should take all of the medication, even after the patient begins to feel better. Assessing a patient's lifestyle when prescribing antibiotics can help with medication adherence; some patients have better adherence with an antibiotic that requires a once daily dose

or one that has a shorter treatment duration. Patients should be discouraged from sharing antibiotics or saving unused antibiotics.

Patient dissatisfaction with not receiving an antibiotic can be mitigated with effective communication. Health care providers should explain that antibiotics are not effective against viral infections, offer symptomatic relief and have patients return for re-evaluation if symptoms do not resolve in a few days.

Appropriate use of antibiotics leads to better health outcomes and more satisfied patients, and it will ultimately help curb the very real public health crisis that can result from antibiotic resistance.

For more information about antibiotic overuse, health care providers can visit the CDC website (http://www.cdc.gov/features/antibioticresistance/).

Flu Vaccinations: A Simple Way to Save Lives

Flu season has begun, and there are some changes for the 2013-2014 vaccination. The Centers for Disease Control and Prevention urges everyone 6 months and older to get an annual flu vaccine. This year's trivalent seasonal flu vaccine will cover the three most common flu strains in the northern hemisphere:

- A/California/7/2009 (H1N1) pdm09-like virus (Same as last year's vaccine)
- A/Texas/50/20121-(H3N2)-like virus (Antigenically like the cell-propagated A/Victoria/361/2011) (New)
- B/Massachusetts/2/2012-like virus (B/Yamagata lineage) (New)

There is also a quadrivalent vaccine available that will include the B/Brisbane/60/2008-like (B/Victoria lineage) virus.

Flu season typically begins in early fall and will likely hit its peak in January and February. Vaccinations should be ongoing now. Humana encourages health care providers to vaccinate patients as soon as the vaccines become available.

While Humana encourages immunization of all people, special emphasis should be placed on the vaccination of the following people because of their increased risk of infections and associated complications:

- Pregnant women
- Children younger than 5, but especially children younger than 2 years old
- People 50 years of age and older
- People of any age with certain chronic medical conditions
- People of any age who have immunosuppression

- People who live in nursing homes and other long-term care facilities
- People who live with or care for those at high risk for complications from flu, including:
    - Health care workers
    - Household contacts of people at high risk for complications from the flu
    - Household contacts and out-of-home caregivers of children less than 6 months of age (these children are too young to be vaccinated)

It is also important for health care providers to record dates of vaccination and to urge patients to do the same.

To find out more, please visit www.flu.gov and click on the "Planning & Preparedness" tab and select the "Health Professionals" option from the drop-down menu to highlight related topics. Additional resources, such as print materials, video and audio tools, can be found on the Centers for Disease Control and Prevention website at http://www.cdc.gov/flu/freeresources/index.htm.

Vaccine Coverage and Codes:

In order to help ensure correct billing and payment, two codes are needed for each vaccination claim, one administrative code and one vaccine code. One code should be selected from each of the following groups:

Administration codes for influenza vaccination include:

- G0008, 90471, 90472, 90473, 90474

Vaccine codes for influenza vaccination include:

- 90654, 90655, 90656, 90657, 90658, 90661, 90662, 90672, 90673, 90685, 90686
- Medicare: Q2033, Q2035, Q2036, Q2037, Q2038

Humana asks that health care providers consider the following guidelines when determining coverage for their Humana-covered patients:

- Commercial Fully Insured – The flu vaccine may be covered 100 percent for members, depending on their group plan.
- HumanaOne® – The flu vaccine may be covered for members depending on their individual HumanaOne plan.
- Administrative Services Only (ASO) – Individual self-insured groups provide Humana direction about coverage.
- Medicare – Most Medicare Advantage members have access to the flu vaccine under their Part B benefit. Humana members with Medicare Part-D-only coverage will not have coverage for the flu vaccine with their Humana benefit. Claims for the flu vaccine submitted for Humana Part-D-only members will result in a denied claim. Part-D-only members may be referred back to Original Medicare or to their medical carrier to determine

how the vaccine is covered. Additionally, Limited Income Newly Eligible Transition (NET) members are not eligible for the vaccine.

Questions about Humana's policies for flu vaccination coding or coverage may be directed to the member/health care provider service phone number on the back of the member's Humana ID card.

Pneumonia Vaccines Protect Young and Old

According to the CDC, pneumococcal pneumonia is the leading cause of vaccine-preventable deaths in the United States, killing one out of every 20 people who contract it. The pneumonia vaccine is most important for young children, those with chronic conditions and older adults.

Humana urges health care providers to dispense pneumococcal polysaccharide vaccine (PPSV) and the pneumococcal conjugate vaccine (PCV) as appropriate.

PPSV

According to the Advisory Committee on Immunization Practices (ACIP), those who should receive the PPSV are:

- People age 65 and older
- People age 2 to 64 who:
    - Have chronic diseases (i.e., cardiovascular, pulmonary, diabetes, alcoholism, liver disease, etc.)
    - Have cerebrospinal fluid leaks or cochlear implants
    - Have functional or anatomic asplenia, including sickle cell disease and splenectomy
    - Have immunocompromising conditions, such as HIV infection, leukemia, lymphoma, or Hodgkin's disease
    - Take a drug or treatment that lowers the body's resistance to infection, such as long-term steroids, certain cancer drugs or radiation therapy
    - Reside in nursing homes or long-term care facilities
    - Are 19 through 64 years old and who smoke or have asthma

A single dose of the PPSV is usually sufficient. However, a second dose is recommended for people older than 65 whose first vaccination occurred when they were younger than 65 and who have not had the vaccine in at least five years.

PCV

The new PCV-13 replaces the previous children's pneumonia vaccine, PCV-7. According to ACIP, all children under the age of 2 should receive the new PCV-13 vaccine in four doses as part of the regular children's immunization series. The following children should also receive the PCV-13:

- Children ages 14 months through 4 years old who previously completed the PCV-7 should also get a single dose of PCV-13 to protect against the additional pneumococcal types in the new vaccine.
- Any unvaccinated child older than 2 years should get one dose of PCV-13.
- A single dose of PCV-13 may be given to children ages 6 through 18 with certain medical conditions — for example, sickle cell disease, HIV infection or other immunocompromising conditions, cochlear implant or cerebrospinal fluid leaks — regardless of whether they have previously received PCV-7 or PPSV.

Flu and pneumonia vaccinations are key to patient health and thus have become important quality metrics for programs such as the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHP).

Revised Provider Manual Available Now, Effective Oct. 21, 2013

A revised version of Humana's Provider Manual (https://www.humana.com/provider/support/publications) is now available and is effective on Oct. 21, 2013. It was last updated in 2010. It's important for all contracted health care providers and administrators to review the new Provider Manual, as your participation agreement with Humana or ChoiceCare Network contains a compliance obligation with the provisions of this manual.

Overall, the Provider Manual has been reorganized and streamlined to make it more user friendly. Similar subjects have been grouped together to help providers quickly locate the information they need. For example, the "Claims Procedures" section now includes information on both utilization management and referrals.

Additional notable revisions in this edition include the following:

- Restructuring of the "Grievance and Appeal" section to detail the specific characteristics of: 1) member grievance/appeals, 2) provider claims reconsiderations and 3) provider termination appeals.
- New language outlining obligations for any and all providers who submit a claim or encounter to Humana that generates a lab test result requiring the provider to submit the corresponding lab result electronically to Humana within 30 days of the member's date of service. This information is critical to Humana's advancement of its quality management and improvement programs. Keep in mind, payments will not be immediately impacted on the effective date of the revised provider manual; Humana will contact providers before there is financial impact. Until contacted, providers need not make any change to what they are doing today.

- Additional language to describe health care providers' contractual obligations to report demographic changes (e.g., name, number, address, new physicians) quickly to Humana. This information confirms that Humana's network filings are accurate, and provider communications can be shared effectively.
- Addition of a new "Compliance/Ethics" section that covers liability insurance; fraud, waste and abuse requirements; notification requirements; conflicts of interest and Medicare obligations.

Requests for printed versions of the manual may be directed to Humana via email to chcpr@humana.com or fax to 1-800-626-1686. Requests must include the name of the provider business, the name of person to receive the manual and the complete address.

Communications Seek to Decrease Adverse Drug Events

Humana is working to decrease adverse drug events (ADE) among its members. By using a new predictive modeling analysis, Humana is identifying members who are likely to have an ADE and contacting those members' health care providers by mail to alert them of the situation.

The letter asks the health care provider to review the identified member's drug regimen and discuss with the member all medications he or she is taking, including those which may have been prescribed by another health care provider. Health care providers are also asked to make sure the patient is aware of the ADE symptoms associated with the medications and monitor the patient closely.

Humana's predictive modeling analysis works to prevent ADEs by identifying common key factors among individuals who experienced these events. In developing the predictive model, Humana analyzed physician-coded ADEs and compared members who experienced ADEs to members who did not. The model's proactive approach excludes the events that happened immediately before the ADE in hopes of predicting ADEs further in advance. For example, if an individual in the analysis had an ADE on May 15, Humana analyzed the individual's information for the months of January, February and March.

The following factors help predict which patients have an increased ADE risk:

- Medical conditions: the presence of heart failure, hyperlipidemia, diabetes, emphysema, cancer and asthma
- Treatment data: a member's medical costs and number of medical claims
- Pharmacy data: the number of drug refills and the number of prescribers
- Risk assessments: medical and prescription risk scores based on Centers for Medicare & Medicaid Services risk adjustment models
- Demographic information

Health care providers who receive an ADE letter will notice that it does not identify which specific drug is leading to the increased risk. However, the predictive model does not include specific drugs. Instead, its holistic approach combines the factors listed above to make the ADE prediction.

Health care providers who have questions about the modeling tool or its application to their patients may call 1-855-812-3737 and leave a message including name and prescriber identification number, the patient's member identification number, the patient's date of birth and a detailed question. A Humana Pharmacy Solutions' representative will return the call as soon as possible.

Remind Patients to Schedule Preventive Screenings

Most medical organizations recommend preventive health screenings. These screenings can lead to early detection of health issues, which may result in better outcomes.

Humana encourages health care providers to remind their Humana-covered patients to get the appropriate health screenings before the end of the year. With the busy holiday season nearing, it is easy for people to forget about making an appointment for a preventive screening.

Health care providers can refer to their Humana-covered patients' Member Summary reports or the Stars Quality Reports to know the specific gaps in care for each individual and send patients reminders about the needed screenings.

Humana suggests its members receive preventive screenings for the following conditions, when appropriate:

- Breast cancer
- Colorectal cancer
- Glaucoma
- Adult body mass index (BMI) assessment

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

Health Care Providers Can Get Paid Up to Seven Days Faster

Humana's EFT (electronic funds transfer) and ERA (electronic remittance advice) Web tools help eliminate the need for paper checks and the delivery time and handling involved.

Health care providers may register to receive Humana electronic remittance advice (ERA) and set up an electronic funds transfer (EFT) account on Humana.com. The enrollment process is quick and easy. For Humana.com:

- Log into Humana.com/providers (registration required)
- Click "ERA/EFT Setup-Change Request" (on the bottom right of the page)
- Complete the form

For more information:

- Click here for additional information about ERAs and EFTs. https://www.humana.com/provider/support/hipaa/era
- Sign up for an ERA/EFT webinar to learn more about the benefits at https://www.humana.com/provider/medical-providers/education/provider-self-service/interactive
- Contact eDeployment@humana.com for assistance

Humana's Web tools are designed to give health care providers a fast, direct way to work with Humana. Web tools help health care providers find ways to save time and streamline administrative processes.

Electronic Claims Submission

Humana encourages health care providers to submit their claims electronically. Submitting claims electronically has many benefits, including the following:

- Avoiding postal delays and saving money that would have been spent on postage costs
- Transmitting claims 24 hours a day, seven days a week
- Submitting faster, more accurate claims that have less chance for errors

Health care providers have a number of options for submitting claims electronically. While Humana has identified Availity® as its central gateway for electronic data interchange (EDI) transactions, health care providers can still submit to a variety of clearinghouses (see below).

Electronic Claim and Encounter Submission Clearinghouses

Clearinghouse	Website	Claims Payer ID	Encounters Payer ID	Phone
Availity	www.availity.com	61101	61102	1-800-282-4548
ZirMed	www.zirmed.com	61101	61102	1-877-494-7633
athenahealth®	www.athenahealth.com	61101	61102	1-800-981-5084
Gateway EDI	www.gatewayedi.com	61101	61102	1-800-556-2231

Clearinghouse	Website	Claims Payer ID	Encounters Payer ID	Phone
McKesson	www.mckesson.com	2449	61102	1-800-782-1334
Capario	www.capario.com	61101	61102	1-800-792-5256
SSI Group	www.thessigroup.com	61101	61102	1-800-881-2739
Inmediata (Puerto Rico only)	www.inmediata.com	61101	61102	1-787-783-3233

Humana Helps Seniors Apply for the Medicare Savings Program

Each state offers a Medicare Savings Program, which can save qualifying Medicare members at least $104.90 per month. However, many seniors do not know about the program or may need help applying. To facilitate the process, Humana's Dual Eligible Outreach department conducts initial eligibility screenings for members and walks them through the application process. (The state makes the final eligibility determination.) Since 2009, Humana's Dual Eligible Outreach program has helped Medicare beneficiaries save more than $150 million.

Health care providers can help by encouraging Humana Medicare Advantage members to call 1-800-889-0550 for more information. Such referrals are especially appropriate when members mention having trouble paying for prescriptions or otherwise hint at financial difficulties.

Humana Dual Eligible Outreach is available Monday – Friday, 9 a.m. – 5:30 p.m. EST. For more information, call 1-800-889-0550.

CMS Explains How to Submit Claims Spanning ICD-10 Transition Date

In June, the Centers for Medicare & Medicaid Services (CMS) released three new Frequently Asked Questions (FAQ) documents dealing with ICD-10 claims submissions. These FAQs update previous information about submitting claims and explain how to split claims for services that span the Oct. 1, 2014, transition date.

Due to the changes CMS is indicating, Humana is now requiring claims with dates of service that extend past Oct. 1, 2014, to be split into separate claims. This means that all services that occur before Oct. 1, 2014, should use ICD-9 codes and should be billed separately from services with dates of service on or after Oct. 1, 2014, which should only contain ICD-10 codes.

Additionally, the date of service determines the compliant code format to be used in a claim regardless of the date the claim is filed or submitted. Providers need to submit claims that occur after Oct. 1, 2014, with ICD-9 codes only when the services were performed prior to Oct. 1, 2014. Humana will process claims received after Oct. 1, 2014, with ICD-9 codes when the services were performed before Oct. 1, 2014. This situation is required in order to be compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Humana will always follow CMS or current state filing requirements and will be consistent in following CMS's guidelines for ICD-9 and ICD-10 bill-splitting practices.

For more information about ICD-10, please refer to CMS at www.cms.gov or visit the ICD-10 site located on Humana's provider portal (https://www.humana.com/provider/medical-providers/education/claims/icd-10/).

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. When available, 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 star 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 each issue of Humana's YourPractice. Medical and behavioral health clinical practice guidelines are available at http://www.humana.com/providers/clinical/clinical_practice.aspx.

Updated Clinical Practice Guidelines

- No updated clinical practice guidelines

New and Revised Pharmacy and Medical Coverage Policies

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

Information about medical and pharmacy coverage policies can be found on Humana.com/provider 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 Policies

- Mekinist (trametinib)
- Tafinlar (dabrafenib)
- Breo Ellipta (fluticasone furoate and vilanterol inhalation powder)

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:

- Acupuncture
- Cosmetic Surgery, Reconstructive Surgery, Scar Revision
- Genetic Testing and Genetic Counseling for Carrier Screening
- Injections for Pain Conditions
- Obstructive Sleep Apnea (OSA) and Other Sleep Related Breathing Disorders Nonsurgical Treatments
- Obstructive Sleep Apnea (OSA) Surgical Treatments
- Rheumatoid Arthritis: Biologic Markers and Pharmacologic Assessment
- Sleep Studies, Adult

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: 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:

- How to do Business with Humana
- Humana*Access*SM Card
- RadConsult™ Online
- Texas Deficiency Tool
- Special Needs Plans (SNPs)
- Humana's Quality Initiatives

The presentations can be accessed around the clock.

Webinars Provide Interactive Learning

The webinar sessions below will assist health care providers in learning how to utilize Humana.com to save time, increase efficiency and help improve the productivity of their practices. These sessions for provider office staff last between 45 minutes and one hour.

2013 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.

- 11 a.m. EST, Wednesday, November 13
- 2 p.m. EST, Tuesday, December 10

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.

- 2 p.m. EST, Thursday, November 7
- 11 a.m. EST, Thursday, December 5

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.

- 11 a.m. EST, Tuesday, November 5
- 11 a.m. EST, Tuesday, December 3

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.

- 11 a.m. EST, Friday, November 15
- 2 p.m. EST, Friday, December 13

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.

- 2 p.m. EST, Tuesday, November 19
- 2 p.m. EST, Tuesday, December 17

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.

- 11 a.m. EST, Friday, October 18
- 2 p.m. EST, Wednesday, November 20
- 11 a.m. EST, Thursday, December 19

Medical Records Management and Resources

The Medical Records Management (MRM) tool allows providers to view requests made from Humana for most medical records. Health care providers who attend this webinar will learn how to manage, submit and close these requests. Also, the webinar teaches how to make demographic changes, view and download contracted reimbursement rates and more.

- 2 p.m. EST, Tuesday, October 29
- 11 a.m. EST, Tuesday, November 26
- 2 p.m. EST, Monday, December 30

ICD-10 Readiness for Provider Offices

Learn about ICD-10 readiness and what Humana is doing. The target audience for this call includes practice managers, physician office managers, medical coders, physicians, physician office staff, nurses and other nonphysician practitioners.

- 2 p.m. EST, Tuesday, October 22
- 2 p.m. EST, Thursday, November 21
- 11 a.m. EST, Friday, December 20

ICD-10 Readiness for Facilities

Learn about ICD-10 readiness and what Humana is doing. The target audience for this call includes patient financial services, authorizations staff, revenue cycle managers, hospital billing associates, health records staff, vendors, laboratories and system maintainers.

- 11 a.m. EST, Thursday, October 24
- 11 a.m. EST, Friday, November 22
- 2 p.m. EST, Monday, December 23

How to Register

To register, send an email to deployment@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.