Humana Medicaid

Fourth Quarter 2017

Updates for Physicians and Health Care Providers

In this issue

New Medicaid Preauthorization List effective April 1

Humana will implement a Florida Medicaid Preauthorization and Notification List for Humana Medical Plan (Medicaid), effective **April 1, 2018**. It will not affect any current processes regarding preauthorizations or notifications for the Medicare and/or commercial lines of businesses. **To determine whether preauthorization is required for a patient with Humana Medical Plan (Medicaid) coverage, physicians or other health care providers should review the Florida Medicaid Preauthorization and Notification List online at Humana.com/PAL.**

Important notes:

- In Florida Medicaid Regions 9, 10 and 11, primary care physicians (PCPs) are responsible for issuing patient referrals. Once a referral has been obtained, a preauthorization needs to be submitted for services requiring preauthorization. Only PCPs may submit preauthorization requests. Urgent/emergent services, as defined in the Florida Medicaid Provider Handbook, do not require a referral or preauthorization.
- In Florida Medicaid Regions 1 and 6, primary care physicians (PCPs) are responsible for issuing patient referrals. Once a referral has been obtained, a preauthorization needs to be submitted for services requiring preauthorization. A preauthorization request can be submitted by either PCPs or designated participating specialists. Urgent/emergent services, as defined in the Florida Medicaid Provider Handbook, do not require a referral or preauthorization.
- Health care providers who participate in an independent practice association (IPA) or other risk network with delegated services should refer to their IPA or risk network for guidance on submitting their preauthorizations.
- If a health care provider does not obtain authorization *prior to the date of service*, it could result in financial penalties for the practice, based on the health care provider's contract.
- Services or medications provided without preauthorization may be subject to retrospective medical necessity review.

If you have questions about Humana's preauthorization requirements, or want to determine if preauthorization is required for a service for a patient with Humana Medical Plan (Medicaid) coverage, please review the Florida Medicaid Preauthorization and Notification List online at Humana.com/PAL or call the Humana Clinical Intake Team at 1-800-523-0023, Monday through Friday, 8 a.m. to 6 p.m. local time.

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Health Network One agreement terminated

Previously, Humana notified physicians and other health care professionals that, effective Nov. 30, 2017, Humana would be terminating its local Medicaid agreement with Health Network One's (HN1's) physical, occupational and speech therapy network in Medicaid regions 6, 9, 10 and 11. **However, this termination has been delayed until Feb. 28, 2018.**

Please note: This affects Humana Medicaid-covered patients younger than 21.

Transition plan:

- Affected Humana Medicaid-covered patients who require physical, occupational and speech therapy services should be referred to a participating therapy provider, which can be located by visiting **Humana.com** and then choosing "Find a doctor."
- Humana Medicaid-covered patients **currently** receiving physical, occupational and speech therapy services from HN1 therapy providers may continue their care uninterrupted during the continuity-of-care period (up to 60 days).
- During the continuity-of-care period, Humana will cover continuing requests for Humana Medicaid-covered patients.
- After the continuity-of-care period, Humana Medicaid-covered patients who require services will need to be transitioned to a participating provider. A new referral will need to be issued to prevent disruption of services.
- Coverage will not change for Humana Medicaid-covered patients. They can continue to receive physical, occupational and/or speech therapy services from participating therapy providers. **Please note: A new referral will be required.**

IF YOU HAVE QUESTIONS, PLEASE CONTACT YOUR HUMANA PROVIDER CONTRACTING REPRESENTATIVE.

Humana adds sickle cell disease to disease management program

Humana's disease management team manages and coordinates care for Humana Medicaid-covered adult and pediatric patients who are diagnosed with diabetes, asthma, congestive heart failure (CHF), hypertension, HIV/AIDS and, now, sickle cell disease and who also agree to participate.

The disease management team assists patients by:

- Completing **post-discharge telephonic outreach** within three days of discharge to identify opportunities for care, address post-discharge needs and assist with making follow-up appointments with the patient's primary care provider (PCP).
- Collaborating with the patient's PCP to discuss the plan of care.
- Working in collaboration with social workers.
- Completing a comprehensive assessment of the patient's current health status.
- Creating an individualized care plan with the patient and working to meet the identified goals.
- Addressing HEDIS measures for patients with gap reports or alerts on file.
- Referring the patient to internal and/or external programs and community resources, as needed (e.g., VillageHealth, RxMentor, Beacon, transplant, etc.).
- Visiting hospitalized patients and PCP centers.
- Participating in monthly interdisciplinary case conferences for patients with complex conditions, working to identify the best course of action for improved outcomes.

Florida Medicaid HCBS Waiver coverage changes Jan. 1, 2018

Florida Medicaid-covered patients who receive home- and community-based services (HCBS) through Traumatic Brain and Spinal Cord Injury (TBI/SCI), Adult Cystic Fibrosis (ACF) or Project AIDS Care (PAC) Waivers will begin receiving HCBS through Humana, effective Jan. 1, 2018**.** The following information may help physicians and other health care professionals in the event an affected patient approaches them with questions:

1. Affected patients **will not** lose Medicaid eligibility as a result of these changes.
2. Affected patients' services **will not** be stopped or changed at this time.
3. Affected patients **will continue** to receive services in their homes and communities.
4. Affected patients do not need to do anything or change their health plan because of this change.
5. A Humana case manager will be coordinating the care for affected patients upon transition to Humana.
6. Affected patients will require a referral or authorization from their primary care physician for these services.

PATIENTS WITH QUESTIONS ABOUT THIS TRANSITION ARE ENCOURAGED TO CALL THE MEDICAID HELPLINE AT 1-877-254-1055.

If you have questions, please contact your provider representative.

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All physicians and health care providers must confirm enrollment in Medicaid

Claims and/or encounters will be denied for physicians and health care professionals with invalid Medicaid enrollment, effective Jan. 1, 2018.

Please refer to the below information regarding Medicaid enrollment requirements and take the necessary steps to confirm your enrollment. This information was shared previously with physicians and other health care professionals contracted with Humana Medical Plan (Medicaid); however, the effective date has been updated to Jan. 1, 2018.

To receive Medicaid reimbursement, a physician or health care professional must be fully enrolled in Medicaid or have "limited enrollment status," as well as meet all provider requirements at the time the service is rendered. Any entity that bills Humana for Medicaid-compensable services provided to Medicaid recipients or that provides billing services of any kind to Medicaid providers must have previously enrolled and registered as a Medicaid provider.

Please note that physicians and other health care professionals can verify enrollment via the Provider Master List on the Agency for Health Care Administration (AHCA) website at http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabId/77/Default.aspx?linkid=pml.

The Provider Master List (PML) is a resource available for all Medicaid health plans and their contracted physicians and health care professionals. The PML contains a listing of all Medicaid providers who are currently registered and/or enrolled with Florida Medicaid with an active status within the last 18 months. Alternatively, the Pending Provider List (PPL) contains a listing of all provider applications that are currently pending with Medicaid. Both lists are located on the Florida Medicaid Public Web Portal within the Managed Care area.

Please access the Provider Master List tip sheet for specific guidance on proper enrollment: http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Managed%20Care/Provider%20Master%20List%20Tip%20Sheet.pdf.

Following are details regarding how a physician or health care professional should be listed:

- Current listing of Medicaid numbers for ALL physicians and health care professionals must be CONFIRMED ACTIVE ON THE AHCA PORTAL on the PML.
- Physician or health care professional must be listed as "ENROLLMENT" or "Limited Enrollment" in the Enrollment Type column and as ACTIVE (A) in the Current Medicaid Enrollment Status column.
- Physician's or health care professional's billing NPI and rendering NPI (as applicable) must be accurate and affiliated with the correct Medicaid ID.
- Physician or health care professional must be enrolled for all practicing provider types and specialty codes.

Incorrect enrollment can affect the way a physician, health care professional or provider group is identified by AHCA and its Choice Counselors, as well as how a physician, health care professional or provider group is listed in Physician Finder, Humana's online provider directory.

AHCA's Provider Enrollment area is available to assist the physician or health care professional with enrollment issues, such as change of address, change of ownership and re-enrollment issues via the AHCA website: http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Enrollment/tabId/42/Default.aspx.

Guidelines on how physicians and other health care professionals should enroll with Medicaid can be found in the Provider's General Handbook Reference Chapter 2: https://www.flrules.org/Gateway/reference.asp?No=Ref-02671.

IF YOU HAVE QUESTIONS ABOUT THESE CHANGES, PLEASE CALL YOUR HUMANA PROVIDER RELATIONS REPRESENTATIVE.

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Patients can receive care from the comfort of their own home

What is telemedicine?

In an increasingly hectic world, some patients have trouble finding the time to visit their physicians for appointments, and urgent care visits can be expensive. Many patients do not want to make an appointment for a minor ailment. For these patients, an alternative to consider is telemedicine.*

Telemedicine is an evaluation, diagnosis or treatment delivered by a practitioner who is not located at the same site as the patient. Your Medicaid-covered patients may use telemedicine for covered services by conferencing with you via video chat (e.g., Skype) from the convenience of their home or care setting.

How is telemedicine reimbursed?

Telemedicine services provided to a patient with Florida Medicaid coverage must be performed by licensed practitioners within their scope of practice. The service is covered under Humana Florida Medicaid plans; however, to be reimbursed by Florida Medicaid for telemedicine services, physicians must use, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between the patient and the physician.

To be reimbursed, physicians need to include the modifier "GT" on their CMS 1500 claim form. Florida Medicaid will reimburse the practitioner who provides the evaluation, diagnosis or treatment recommendation.

Important exceptions:

Florida Medicaid does not reimburse for:

- Telephone conversations
- Chart review(s)
- Electronic mail messages
- Facsimile transmissions
- Equipment required to provide telemedicine services

**There are limitations on health care and prescription services delivered via telemedicine. Telemedicine is not a substitute for emergency care and is not intended to replace your patient's primary care physician or other health care professionals in your patient's network.*

THESE RESOURCES ARE AVAILABLE TO HELP:

The following links provide additional details on payment and plan coverage:

- http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml
- **Humana.com/floridamedicaid** – Choose "Florida Medicaid Provider Handbook" under the appropriate tab for your Florida Medicaid Region.

Need guidance providing telemedicine services?

IF YOU ARE CURRENTLY PROVIDING TELEMEDICINE OR CONSIDERING TELEMEDICINE FOR YOUR PATIENTS WITH HUMANA MEDICAL PLAN (MEDICAID) COVERAGE, PLEASE CONTACT YOUR HUMANA PROVIDER REPRESENTATIVE.

Annual compliance training requirements due for 2017

Physicians and other health care professionals are required to complete the following training modules each year:

- Humana Medicaid Provider Orientation
- Health, Safety and Welfare Training
- Cultural Competency
- Compliance and Fraud, Waste and Abuse Training

Find the training modules by logging in at Humana.com/providers (registration required) or www.availity.com (registration required). More information is available on Humana's website at Humana.com/provider/support/clinical/medicaid-materials/florida by choosing the "Health Care Provider Training Materials" tab.

2018 materials will be available in February.

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100 percent encounter submissions required for Florida Medicaid

HUMANA'S GOAL: 95% PASS RATE THROUGH STATE SYSTEM

- Three key items to ensure compliance are:
  1. Capitated providers must submit encounters/claims billed charges instead of zero dollars.
  2. Encounter information must match the provider's information exactly how it is registered with the AHCA.
- Consequences of noncompliance
  - Fines
  - Enrollment freezes
  - Claims and/or encounters denials
- Benefits of submitting encounters
  - Identifies patients who have received preventive screenings and other important services
  - Decreases the need for medical record review during Healthcare Effectiveness Data and Information Set (HEDIS®) audits
  - Is critical for Medicaid Risk Adjustment
  - Decreases the number of patients listed in gap reports

How to avoid encounter submission errors

- Common reasons for encounter rejection or denial:
  - An encounter with an incorrect NPI, ZIP code or taxonomy is submitted. (Please note: NPI, taxonomy and ZIP+4 are referred to as the NPI Crosswalk.)
  - NPI, ZIP code or taxonomy is missing.
  - Zero-dollar value is submitted.
- How to avoid these errors:
  - Confirm and submit all provider information exactly how it is registered with AHCA.
  - Verify provider enrollment via the PML on the AHCA website.
  - Ensure billed amounts are not zero dollars, and instead, submit billed charges.
  - Use the correct NPI for the following provider types: rendering, referring, ordering and attending.

How to identify and avoid common claims submission errors

- Common reasons for claims rejection or denial:
  - Patient not found
  - Insured subscriber not found
  - Invalid Healthcare Common Procedure Coding System (HCPCS) code submitted
  - No authorization or referral found
  - Billed amount missing
  - National Drug Code (NDC) not covered or invalid
- How to avoid claims submission errors:
  - Confirm that the patient information received and submitted is accurate.
  - Ensure that all required claim form fields are completed and accurate.
  - Obtain proper authorizations and/or referrals for services rendered.
  - Ensure billed amounts are not zero dollars.

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