

Thumbnail headline: Thoughts from our chief medical officer Humana Looks Homeward

Dr. Shrank

One of the things that really attracted me to Humana was our model, which integrates the payer and the provider around patients in the home. A big focus of my work prior to Humana was about understanding how the payer and provider can better integrate – how to align incentives to foster deep partnership. I spent time at CMS in the Center for Medicare & Medicaid Innovation working on value-based payment models; at a large, vertically integrated health system with a health plan; and at a retail pharmacy partnering with risk-bearing providers. I think our model – to deliver more patient-centered, convenient care in and around the home – is the right one, and we are poised to meaningfully disrupt the marketplace.

One of the things that is cool about working for a Medicare Advantage plan is that we have a lot more flexibility concerning how we engage and support home healthcare and how we work with our network physicians. Providing actionable data and promoting data interoperability are essential so that physicians and other healthcare providers can have an expanded view of their patient's health picture. At Humana, we're able to be more creative and cooperative in supporting physicians working to improve the health of their patients.

Right now, part of that expanded health picture includes understanding the breadth of patients' social, behavioral and physical health needs. We've heard a lot of discussion about social determinants of health (SDoH), and many of you are likely already incorporating these facets into your practices. Medscape and the American Academy of Family Physicians (AAFP) recently surveyed primary care physicians around SDoH and the [results](#) were pretty interesting.

For me, it's clear that by working closely with our physicians, community partners and other healthcare providers within the flexibility of a Medicare Advantage plan, we can be most innovative and nimble to meet the needs of those we serve, improving health while reducing cost.

William Shrank, M.D.

Chief Medical and Corporate Affairs Officer

Thumbnail headline: Fixing food insecurity Treating food insecurity as a clinical gap in care

Drs. Toyin Ajayi and Andrew Renda

A group of physicians and healthcare leaders convened at a recent Humana event to discuss what the medical practitioner's role should be in addressing food insecurity as part of improving patient outcomes. Below, Drs. Ajayi and Renda summarize the discussion.

It's an unfortunate truth that in our current healthcare system, too-short, too-packed appointments often mean that providers do not have time to understand all that is going on with their patients beyond the walls of their practices. While the treatments we prescribe address their physical symptoms, we know little about the social, economic and environmental challenges our patients face that impede their health. These social determinants of health (SDoH) – such as reliable transportation, nutritious food, stable housing, community and human connection – are critical to health and well-being. Yet, the way that medicine is still widely practiced, especially in lower-income communities, is extremely costly and fragmented, and it fails to produce the health outcomes and cost efficiencies we all want.

One of the most prevalent, most harmful barriers to good health is lack of access to enough nutritious food. Food insecurity leads to higher rates of chronic disease, emergency department visits and hospitalizations, driving \$77.5 billion in related healthcare costs. We cannot expect to improve health and reduce costs if we do not first ensure that patients eat well. This is no small issue: Adults experiencing poverty, who presumably lack consistent healthful food, are at higher risk for diabetes, heart disease, stroke, depression, disability – even premature mortality.

So why is food insecurity not considered a clinical gap in care? Shouldn't all providers have a responsibility to diagnose SDoH as they would other medical conditions?

These were the questions posed to a group of physicians and healthcare leaders at a recent TEDMED event, convened by Humana, at which participants sought to understand what the medical practitioner's role should be in addressing food insecurity as part of improving patient outcomes.

Addressing food insecurity will require a major restructuring of the roles and responsibilities of healthcare providers. Beyond that, we need to implement interventions using technology platforms, validated screening tools and referral sources, as well as new code sets and payment models, to enable physicians to make food-insecurity assessment standard practice.

How do we make this work?

Community provider-driven care teams. For physicians to feasibly address food insecurity and other SDoH requires a significant shift to a team-based approach, one reaches well beyond the walls of the medical practice and into the communities where patients live.

This team-based, flexible approach is the foundation that Cityblock Health is built on. Multidisciplinary care teams are led by Community Health Partners – individuals from within the community who understand the experiences of people living there. Community Health Partners meet patients where they are, taking time to understand what is going on in their lives and connecting them to the right

resources. They enhance the clinical team’s understanding of patients’ realities and design interventions for their specific needs. Team-based models necessitate a significant role change for physicians, who will have to work closely with non-medical, community-based partners.

Value-based care. Few reimbursement systems are currently set up to adequately pay medical practices for time and resources spent treating SDoH. Value-based models, in which reimbursements depend on patient outcomes, encourage and allow room for care teams to address all aspects of health – from medical and behavioral health conditions to social needs – as equally critical in every patient’s care.

In value-based care models, then, we need to develop clear measures tied to addressing social determinants of health and their impact on outcomes.

Evidence and outcomes. Currently, there is limited evidence showing which approaches to SDoH are most effective at improving health outcomes and providing a return on investment. However, one example showing real benefits is the provision of medically-tailored, home delivered meal programs for the elderly. These programs have been shown to improve clinical outcomes, including blood pressure and diabetes control, and to help curtail emergency department visits and inpatient admissions for adults who are dually eligible for Medicaid and Medicare.

It’s critical that we establish methods and metrics to expand evidence-based programs and measure various approaches that address SDoH. As part of that effort, Humana is currently working with the National Quality Forum to define quality measures around food insecurity. This effort will enable us to standardize benchmark measurements and expectations to help physicians effectively address food insecurity and to incentivize and compensate based on validated measures tied to patient outcomes.

We’re in the early stages, but there is growing momentum for treating SDoH as clinical gaps in care. To make real progress toward that end, decision-makers across healthcare – from policymakers to health plan and health system executives – need to align on a shared vision and efforts to address patients’ comprehensive health and social needs. Physicians alone cannot cure food insecurity, but we can be powerful partners in holistically addressing the needs of our patients and communities.

Toyin Ajayi, M.D., is the chief health officer at Cityblock Health, and Andrew Renda, M.D., is associate vice president, population health strategy, Bold Goal, at Humana.

Thumbnail headline: Success in value-based care

Assembling the missing pieces to achieve success in value-based care

At the 3rd Annual Value-Based Care Summit, hosted by Xtelligent Healthcare Media, Humana convened a group of forward-thinking industry leaders to discuss the obstacles, opportunities, and gaps in research surrounding value-based care.

“Our goal was to listen carefully to understand how Humana can remove barriers and make it easier to transition to value-based care while improving patient outcomes,” said Worthe S. Holt, MD, vice president, Humana.

The group of clinical executives, quality improvement experts, physicians and other advanced practitioners and population health management directors identified several main obstacles affecting their ability to transition smoothly to value-based care. Additionally, these healthcare leaders offered a number of solutions to some of the most pressing questions facing healthcare.

Read a summary of the findings [here](#).

Thumbnail headline: Care Highlight™ is here Humana’s Care Highlight™ program is up and running

Patients have many choices when it comes to their care. To help inform their choices, Humana’s Care Highlight™ Program aims to equip your Humana patients, as well as prospective Humana customers, with information about provider clinical quality and cost efficiency.

As part of this program, Humana shares physician performance ratings on the Find a Doctor tool at Humana.com. The primary intent of the program is transparency with customers. The ratings should be used only as a guide, and patients are encouraged to consider all relevant information and consult with their treating physicians when selecting a specialist.

The program was recently awarded the National Committee for Quality Assurance’s Physician Quality (PQ) seal. The PQ seal represents the gold standard in physician measurement.

We appreciate your input to our programs and want to hear your ideas for improvement. To learn more about the Care Highlight™ program or to give us feedback on the program, please visit humana.com/carehighlight.

Thumbnail headline: The risk of polypharmacy Headline: Poly•pharmacy risks in older adults

[Sidebar]

Poly•pharmacy

noun

Derived from the Greek words for “many” (*poly*) and “drug” (*pharmacon*)

- While there is no absolute definition for polypharmacy, most clinicians agree that it signifies the patient taking five or more medications.
- The term also describes the use of more medications than are medically necessary. Medications that are not indicated, are not effective or constitute a therapeutic duplication are considered polypharmacy.¹

[BEGIN ARTICLE]

Potentially inappropriate medication is a patient safety issue for our older adult population, especially for those who have multiple chronic conditions and take multiple medications.

Nearly 50% of older adults take one or more medications that are not medically necessary. Research has clearly established a strong relationship between polypharmacy and negative clinical consequences.¹ Some of those consequences are:

- **Increased healthcare costs:** Polypharmacy contributes to a rise in costs for both the patient and the healthcare system. The elevated risk of outpatient visits and hospitalization stemming from taking a potentially inappropriate medication can increase medical costs by approximately 30%.²
- **Higher risk of adverse drug events (ADE):** Patients taking five or more medications had an 88% greater risk of experiencing an ADE compared with those taking fewer medications.³
- **Drug-to-drug interactions:** The likelihood of a drug-to-drug interaction increases 50% if a patient is taking five to nine medications. That risk jumps to 100% when a patient's regimen includes 20 or more medications.⁴
- **Nonadherence to medications:** Patients taking four or more medications are 35% more likely to not adhere to their regimen.⁵
- **Mental and physical risks:** Polypharmacy is associated with functional decline and cognitive impairment in older adults. Falls that result from polypharmacy may lead to increased morbidity and mortality.¹

The American Geriatrics Society (AGS) Beers Criteria focuses on opportunities to decrease ADEs and complications for patients. AGS recommends:

- Avoiding concurrent use of three or more central nervous system (CNS) medications, as such use increases a patient's risk of falling
- Avoiding concurrent use of anticholinergic (ACH) medications, due to an increased risk of cognitive decline

In 2013, the Centers for Disease Control and Prevention (CDC) reported that opioids were associated with the most pharmaceutical-related overdose deaths in 2010 (75.2%), followed by benzodiazepines (29.4%). Concurrent use of benzodiazepines was associated with 30.1% of opioid overdose deaths, and concurrent opioid use was associated with 77.2% of benzodiazepine overdose deaths.⁶

For information about prescribing opioids, consult the following guides.

- [Turn the Tide Opioid Pocket Guide](#)
- [CDC Pocket Guide – Tapering Opioids for Chronic Pain](#)

Based on extant evidence, the Pharmacy Quality Alliance (PQA) developed and endorsed two polypharmacy measures for older adults and a performance measure to reduce the combined use of opioids and benzodiazepines:

- Polypharmacy: Use of Anticholinergic Medications in Older Adults (POLY-ACH)
- Polypharmacy: Use of Multiple Central Nervous System Medications in Older Adults (POLY-CNS)
- Concurrent use of Opioids and Benzodiazepines

The Centers for Medicare & Medicaid Services adapted these three performance measures for display in 2021 (using 2019 data) and 2022 (using 2020 data). [Learn more.](#)

References:

1. Maher RL, Hanlon JT, Hajjar ER. Clinical consequences of polypharmacy in elderly. *Expert opinion on drug safety*. 2014; 13(1): 10.1517/14740338.2013.827660.
2. Akazawa M, Imai H, Igarashi A, Tsutani K. Potentially inappropriate medication use in elderly Japanese patients. *The American Journal of Geriatric Pharmacotherapy*. 2010; 8:146–160.

3. Bourgeois FT, Shannon MW, Valim C, et al. Adverse drug events in the outpatient setting: an 11-year national analysis. *Pharmacoepidemiology and Drug Safety*. 2010; 19:901–10.
4. Doan J, Zakrewski-Jakubiak H, Roy J, et al. Prevalence and risk of potential cytochrome p450-mediated drug-drug interactions in older hospitalized patients with polypharmacy. *Annals of Pharmacotherapy*. 2013; 47:324–32.
5. Rollason V, Vogt N. Reduction of polypharmacy in the elderly: a systematic review of the role of the pharmacist. *Drugs & Aging*. 2003; 20:817–32.
6. Jones CM, Mack KM, Paulozzi LJ. Pharmaceutical overdose deaths, United States, 2010. *JAMA* 2013; 309(7):657-659. doi:10.1001/jama.2013.272. CDC guideline for prescribing opioids for chronic pain. <http://www.cdc.gov/drugoverdose/prescribing/guideline.html>.

Thumbnail headline: Original Medicare E/M requirement
Headline: Clarification of E/M service documenting requirements

At the beginning of 2019, the Centers for Medicare & Medicaid Services (CMS) outlined changes in how providers should document evaluation and management (E/M) services for Original Medicare. Some providers have asked us if Humana is adopting those changes. We are not. CMS has not indicated that those changes apply to Medicare Advantage plans.

Key points:

- For 2019, CMS outlined Original Medicare changes to E/M documentation that will allow practitioners to avoid repetitious entries in the medical record.
- The changes address documentation of procedural elements that previously were required for various levels of E/M coding and claims payment.
- The rule does not impact CMS' Part C Medicare Advantage guidance requiring accurate and complete documentation, to the highest degree of specificity, for all conditions coexisting at the time of the encounter and requiring or affecting patient care management or treatment.
- For services provided to Medicare Advantage enrollees, practitioners should continue to document the relevant clinical information that supports every condition for all encounters.

Thumbnail headline: Help to improve your claim submissions
Headline: New Topics in the Making It Easier Series

Body text: The Making It Easier series is a library of information about Humana's claims payment policies and processes, with each topic addressed separately for easy access. The library includes a narrated video presentation and a printable tip sheet for each topic, all available 24/7 to be viewed at your convenience.

We continue to improve the Making It Easier series based on your feedback. Two topics added recently are highlighted below.

Claim Disputes and Corrected Claims: This material provides guidance about how to dispute a claim outcome or submit a corrected claim. It includes a description of each action and the criteria for

determining which approach is correct. The presentation also outlines the information to be submitted and the process for each. It applies to medical claims only.

Understanding an Explanation of Remittance (EOR): This presentation provides guidance about how to access a remittance using Humana's online tools and how to interpret the information provided on remittances.

Other topics that have recently been updated include:

- Humana's Maximum Unit Values
- Application of Medicare NCD/LCD Guidelines
- Modifiers 59 and X{EPSU}

Look for these new presentations, and additional topics at [Humana.com/MakingItEasier](https://www.humana.com/MakingItEasier).



Thumbnail headline: Find Humana's claims payment policies online
Headline: Updated claim payment policies available

Humana publishes its medical claim payment policies online. Information about reimbursement methodologies and acceptable billing practices may help physicians and other healthcare providers and their billing offices bill claims more accurately. This could reduce delays, rebilling and requests for additional information. Find the policies at [Humana.com/ClaimPaymentPolicies](https://www.humana.com/ClaimPaymentPolicies).

Humana recently published new policies on the following topics:

- Missed appointments
- Ambulance transportation to a prior-authorized facility
- Electronic transactions
- Obstetrics



Thumbnail headline: Latest changes to medical coverage policies
New and revised 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 healthcare organizations.

Information about medical and pharmacy coverage policies can be found at [Humana.com/CoveragePolicies](https://www.humana.com/CoveragePolicies) by selecting "Medical and Pharmacy Coverage Policies" under "Resources." Policies can be reviewed by name or revision date. Users also may search for a particular policy using the search box. More detailed information can be found by reviewing "How to Read a Medical Coverage Policy" and "Understanding the Medical Coverage Policy Development Process" under "Helpful Links."

Recent changes to medical and pharmacy coverage policies are listed below.

New Policies

- Molecular Testing for HLA-B*27 for Ankylosing Spondylitis

Policies with Significant Revisions

- Attention Deficit Hyperactivity Disorder (ADHD) – Diagnosis and Treatment
- Bunion and Bunionette Surgical Treatments
- Chiropractic Care
- Code Compendium (miscellaneous)
- Cognitive Rehabilitation
- Deep Brain Stimulation (DBS) and Cortical Brain Stimulation
- Direct-to-consumer (DTC) Laboratory Testing and Mobile Health (mHealth) Applications
- Fusion Imaging
- Genetic Testing for Hereditary Ataxias
- Genetic Testing for Muscular Dystrophy and Spinal Muscular Atrophy
- Implantable Infusion Pumps for Pain or Spasticity
- Injections for Chronic Pain Conditions
- Mobility Assistive Devices (wheelchairs)
- Molecular Diagnostic Testing for Reproductive Health
- Molecular Markers in Fine Needle Aspirates of Thyroid Nodules
- Pharmacogenomics and Companion Diagnostics
- Pharmacogenomics – Cytochrome P450 Polymorphisms and VKORC1
- Platelet Derived Growth Factors for Wound Healing
- Prosthetics
- Reduction Mammoplasty
- Rheumatoid Arthritis: Biologic Markers and Pharmacologic Assessment
- Sleep Studies, Adult

Thumbnail headline: Humana conference schedule Look for Humana at a Conference near You

Humana will be attending the following conferences in 2019:

- [American Academy of Family Practitioners \(AAFP\), Sept. 24–28, Philadelphia, Pennsylvania](#)
- [Medical Group Management Association \(MGMA\), Oct. 13–16, New Orleans, Louisiana , opens new window](#)

Physicians and other healthcare providers are encouraged to mark their calendars for these events. Humana representatives look forward to meeting all types of healthcare practitioners.

The transition to value

Humana's 2020 Value-based Care Report

Helping people achieve their optimal whole-person health has long been a strategic imperative for Humana. To that goal, a new report shows that the company has lowered overall healthcare costs and helped deliver improved health outcomes for Humana Medicare Advantage beneficiaries affiliated with physicians in value-based payment models.

The annual Value-based Care Report, which can be accessed [here](#), details how Humana uses a holistic approach to help beneficiaries manage numerous physical, behavioral and social challenges.

In particular, the report examines a number of social determinants of health, such as food insecurity and social isolation, and examines how physicians are managing and engaging patients to promote better chronic disease management and improve health outcomes.

The report's key findings:

- Humana Medicare Advantage members under the care of physicians in value-based agreements would have incurred an additional \$3.5 billion in plan-covered medical expenses had they been under Original Medicare's fee-for-service model. Prevention screenings, improved medication adherence and effective management of patient treatment plans all contributed to creating these reductions.
- Humana Medicare Advantage members served by physicians/practices in value-based agreements had a 27% lower rate of hospital admission (131,200 fewer admissions) and visited emergency rooms 14.6% less often (110,700 fewer visits) compared with Original Medicare.
- Physicians in value-based agreements with Humana from 2016 through 2018 had a 4.44 average Healthcare Effectiveness Data and Information Set (HEDIS®) Star score at the end of 2018 based on 1.13 million Humana MA members, compared to a 3.10 HEDIS Star score for physicians serving 454,000 members in non-value based agreements.
- Humana Medicare Advantage members affiliated with physicians in value-based agreements received screenings as much as 21% more often in categories such as colorectal cancer, osteoporosis and blood sugar control than those in an MA non-value-based setting.

2020 Vaccination Information

Fighting the flu in 2020

The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months and older get an annual flu vaccine.

The 2019 – 2020 trivalent seasonal flu vaccine covers the three flu strains that research suggests will be most common in the northern hemisphere:

- A/Brisbane/02/2018 (H1N1)pdm09-like virus
- A/Kansas/14/2017 (H3N2)-like virus
- B/Colorado/06/2017-like (B/Victoria/2/87 lineage) virus

Also available is a quadrivalent vaccine that will include the B/Phuket/3073/2013-like virus (Yamagata lineage).

Also relevant for the 2019-20 season:

- The Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP) recommend that any licensed influenza vaccine appropriate for the age and health status of a patient can be used with no specific preference given to either the LAIV4 (nasal spray) or inactivated influenza vaccine (shot).
- **Humana data confirms the appropriateness of the high-dose flu vaccine for older adults.** In a study presented at the American Public Health Association annual meeting in November 2018, high-dose trivalent vaccine for prevention of flu was more effective than standard-dose trivalent and standard-dose quadrivalent vaccines. [View the full research here](#). [View the infographic here](#).

Preauthorization news

The 2020 PAL, OrthoNet review and a useful tip

Preauthorization list updates. Humana has updated its preauthorization and notification lists for all commercial fully insured, Medicare Advantage (MA) plans and dual Medicare-Medicaid plans. The lists now include all CPT and HCPCS codes that require an authorization, making them more user friendly. The lists can be found [here](#).

A tip for faster approvals

Did you know that you can get speedier approvals for select services on Humana's preauthorization list? Just enter the Availity Portal, answer a few clinical questions and upload relevant clinical information. If all necessary criteria are met, Humana will instantly approve your request. And even if it doesn't, the

answers you provide on the questionnaire and the information you upload will help Humana complete the review more quickly.

To save time when submitting your request for instant authorization, have on hand relevant clinical information from the patient's chart, including:

- Standard authorization information, such as requesting and servicing provider and/or facility
- Patient's signs and symptoms and their duration
- Related prior diagnostic tests and results
- Related patient medications and duration
- Relevant prior treatments or other clinical findings

All you have to do is sign in to the Availity Portal and create a typical authorization request, then check for the "Click to Complete Questionnaire" button. If the button is present, you can use it to expedite your preauthorization request. Click it, answer the questions, and you'll receive an immediate decision about preauthorization. If your request is pended, upload the relevant clinical information.

OrthoNet to review outpatient services in 2020

Starting Jan. 1, 2020, OrthoNet will begin clinical review of pre-authorization and retro-authorization (pre-claim) requests for outpatient therapy services. Review will include physical, speech and occupational services performed by licensed therapists in freestanding locations, physician offices, outpatient hospitals and skilled nursing facilities (when a member is not admitted to the SNF). OrthoNet will not review therapy services performed by chiropractors or services performed by licensed therapists in the home or while members are admitted to a hospital or SNF.

For therapy episodes of care that commence prior to Jan. 1, 2020, prior authorization will not be required for visits that occur before Feb. 1, 2020. After Feb. 1, prior authorization will be required. All members starting therapy on or after Jan. 1, 2020, will require all visits, other than the initial evaluation, to be prior authorized.

Healthcare providers should submit therapy requests directly to OrthoNet via its web portal, phone (1-844-938-0346) or fax (1-844-938-0353). Providers not currently registered are encouraged to visit www.orthonet-online.com or www.myoptumhealthphysicalhealth.com to create a user login prior to their first request. Doing so will allow time for processing.

Pharmacy news

Changes announced for 2020 formularies

Beginning Jan. 1, 2020, certain drugs will have new limitations or will require utilization management (e.g., prior authorization [PA] requirements, step therapy [ST] modifications and nonformulary [NF] changes) under the Humana commercial and Medicare formularies for the 2020 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. Find all the details [here](#).

Medicaid news

Humana takes over from CareSource

Kentucky Medicaid Update – Humana and CareSource have terminated the current alliance between the companies servicing the Kentucky Medicaid market, effective Dec. 31, 2019. Humana will become the existing contract’s sole administrator effective Jan. 1, 2020. We’ll have more news about this transition soon. Visit our [Kentucky Medicaid](#) page for more information.

CMS change in claim ID for 2020

The MBI has replaced the HICN

The Centers for Medicare & Medicaid Services (CMS) completed the transition from the older Social Security number-based Medicare ID, also known as a Health Insurance Claim Number (HICN), to a new Medicare Beneficiary Identifier (MBI). Please remember that you must not use the the older HICN after Dec. 31, 2019.

Humana Medicare Advantage members should continue to present their Humana Medicare ID card when receiving medical services.

CMS transitioned to the new MBIs to help protect Medicare beneficiaries from identity theft. New Medicare ID numbers and ID cards were issued to all Medicare beneficiaries between April 1, 2018, and April 1, 2019.

Additional information about this change is available on CMS’ [“What do Medicare Beneficiary Identifiers \(MBIs\) mean for health care providers & office managers?”](#) webpage.

New CMS SNF reimbursement policy

From RUGS to PDPM for SNF PPS

On Oct. 1, 2019, the Centers for Medicare & Medicaid Services (CMS) changed the reimbursement methodology for the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) from resource utilization groupings (RUGs) to the new Patient Driven Payment Model (PDPM).

To submit claims to Humana, healthcare providers should update their billing in accordance with CMS guidelines.

Humana will apply the new payment methodology where applicable and in accordance with CMS guidelines when paying the Medicare allowed amount.

A new authorization is required for Humana-covered patients discharged from an SNF after midnight. However, consistent with CMS' interrupted stay policy, the new authorization will not reset the variable per diem adjustment schedule. Humana will continue to determine pricing for these claims based on CMS' interrupted stay rules.

Providers who receive authorization from naviHealth should continue to follow the required Omnibus Budget Reconciliation Act (OBRA) Assessment Schedule, as directed by naviHealth, and use the PDPM code they received from naviHealth when submitting their claims. All other providers should follow CMS' expectations and schedule of assessments – as outlined by the CMS RAI-MDS 3.0 and Medicare billing manuals.

If you have questions, please contact your Humana market contractor representative as soon as possible.

For additional information about SNF PDPM, you can visit the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>.

Annual compliance training

Mandatory compliance training in 2020

If your organization supports Humana's Medicare Advantage plans, prescription drug plans and/or Medicaid plans, the Centers for Medicare & Medicaid Services (CMS) and Humana require that you, your employees and contractors receive training on fraud, waste and abuse (FWA) at orientation and annually thereafter.

For FWA training, your organization is responsible for:

- Creating or adopting FWA training content
 - If you prefer, you may use FWA material CMS posts on its website; or
 - You may use content pertaining to FWA from Humana's Standards of Conduct and Compliance Policy documents to supplement other training material. These documents are found on www.Humana.com/Fraud.
- Conducting and tracking the training

If your organization supports special needs plans and/or a Medicaid plan:

- Annual training separate from FWA training is required.

- Humana requires applicable organizations to submit an attestation to certify the SNP training and/or Medicaid training has been conducted this calendar year.

Visit our website today at www.Humana.com/ProviderCompliance for additional information on these training requirements.

Education and training

The Making It Easier series is even easier to access

Accessing a Making It Easier presentation is now easier than ever. When you click on the topic you have selected, the presentation will start immediately. The Guestbook has been removed, giving you easier access to all the information and other features on the page.

Two new topics have been added to this library of information about Humana's claims policies and processes.

Modifiers 76 and 77

This topic addresses Humana's policy on the use of modifiers 76 and 77 to indicate that a service is a repeat procedure. This presentation applies to claims submitted for professional and facility services for your patients with Humana Medicare Advantage, commercial and select Medicaid plans.

Genetic Testing: Billing and Coding for Medical and Laboratory Providers

This topic addresses Humana's billing expectations for coverable medically necessary genetic testing and how Humana will adjudicate and reimburse claims for those covered services. This information applies to claims submitted for your patients with Humana Medicare Advantage, select commercial and select Medicaid plans.

Other recently updated presentations include:

- Tools and Resources for Physicians and Other Healthcare Providers
- Use of Non-Specific Procedure Codes
- Anatomical Modifiers
- Procedure-to-Procedure Code Editing

Look for these presentations and additional topics at Humana.com/MakingItEasier (<https://www.humana.com/provider/support/tools/making-it-easier>).

Claim payment policies

Find Humana's claims payment policies online

Humana publishes its medical claims payment policies online. The information about reimbursement methodologies and acceptable billing practices may help physicians and other healthcare providers and their billing offices bill claims more accurately. This could reduce delays, rebilling and requests for additional information. Find the policies at Humana claims payment policies. [LINK: www.humana.com/claimpaymentpolicy].

We recently published new claims payment policies on the following topics:

- Inpatient Readmission Review
- Modifiers CO and CQ

And we updated the following policies:

- Chronic Care Management and Principal Care Management
- Telehealth Services

Medical coverage policies

New and revised medical coverage policies

New Policies

- Code Compendium (Laboratory)
- Prostatectomy

Policies with Significant Revisions

- Biofeedback
- Bone Density Measurement
- Capsule Endoscopy
- Carpal Tunnel Syndrome (CTS) Surgical Treatments
- Cold Therapy Devices/Heating Devices/Combined Heat and Cold Therapy Devices
- Comparative Genomic Hybridization/Chromosomal Microarray Analysis
- Cosmetic Surgery, Reconstructive Surgery, Scar Revision
- Diagnostic Esophagogastroduodenoscopy (EGD) or Esophagoscopy (age 59 or younger)
- Drug Testing
- Electrical Stimulators for Pain and Nausea-Vomiting
- Extended Ophthalmoscopy
- Fecal Incontinence Treatments
- Genetic Testing for Angelman Syndrome and Prader Willi Syndrome
- Genetic Testing for Carrier Screening
- Genetic Testing for Colorectal Cancer Susceptibility
- Left Atrial Appendage and Cardiac Structural Defect Closure for Stroke Prevention
- Multianalyte Assays with Algorithmic Analyses (MAAAs)
- Noninvasive Prenatal Screening

- Obstructive Sleep Apnea (OSA) and Other Sleep Related Breathing Disorders Nonsurgical Treatments
- Pharmacogenomics and Companion Diagnostics
- Serological and Fecal Testing for Inflammatory Bowel Disease (IBD)
- Skin and Tissue Substitutes Spinal Decompression Surgery
- Spinal Fusion Surgery
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)
- Ultraviolet Light/Laser Therapy for Skin Conditions
- Urinary Incontinence Evaluation and Treatments

Recent Humana research

U.S. healthcare wastage approaching \$1T; and more

Featured research: Humana research unveils up to \$935 billion of annual waste in the US health system

It has been nine years since Donald M. Berwick, M.D., MPP, and Andrew D. Hackbarth, MPhil, demonstrated that over 30% of healthcare spending is waste. Considering the attention healthcare costs are getting in our political landscape and the unsustainable rise in healthcare costs, we wanted to reassess. Our study demonstrated that the total waste estimate was between \$760 to \$935 billion per year, or approximately 25% of U.S. healthcare expenditures. The study provides separate estimates for six previously recognized waste domains: failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse and administrative complexity. Chief Medical Officer Dr. William Shrank's team built on the previously published cost of waste estimates by estimating potential savings from scaling up interventions shown to reduce those wasteful expenditures. Potential savings ranged from \$191 to \$282 billion per year.

The study, "[Waste in the US Health Care System. Estimated Costs and Potential Savings](#)," was published online Oct. 15, 2019. View a related infographic [here](#).

Check out these other recent publications:

- ✦ Responding to Dr. Roy Beveridge's leadership, a Humana-funded panel of **18 experts met to develop practical, broadly applicable definitions** for the terms value-based care, value-based payment and population health. View the research [here](#).
- ✦ We know that **increased PCP visits may lead to improved health of patients with diabetes**, but what's the sweet spot? This research adds to the data needed to establish evidence-based guidelines for primary care provider encounter cadence. View the research [here](#).

- ✦ **This review collected 15 studies analyzing discordant recommendations in guidelines on indications for imaging. Findings of this review might help clinicians more thoughtfully use guidelines and appropriate use criteria.** View the research [here](#).
- ✦ **Value-based payment arrangements** with physicians appear to encourage greater use of primary care resources and less reliance on emergency department care. Results should be interpreted with caution because of several study limitations. We may learn more from longer follow-up of the same patient cohort. View the research [here](#).
- ✦ **Scoring algorithms for the Charlson Comorbidity Index (CCI) received a much-needed update.** Prior to this research, no coding scheme had been published that included both ICD-9 and ICD-10 code tables for the 19 medical conditions that comprise the CCI score. View the research [here](#).

Ways to connect: Have questions or want to share ideas for other research opportunities? Please write to research@humana.com.

Interested in seeing more research? Visit Humana's research site to learn about past research projects, listen to podcasts, and view videos that showcase Humana's commitment to research. Access our highlighted research [here](#) or visit our full research library [here](#).



Humana Updates Preauthorization and Notification Lists for 2019

On Jan. 1, 2019, Humana will update its preauthorization and notification lists for all commercial fully insured, Medicare Advantage (MA) plans and dual Medicare-Medicaid plans.

Preauthorization will be required for the following medical services:

- Ablation (bone, liver, kidney, prostate)
- Capsule endoscopy
- Decompression of peripheral nerve, i.e., carpal tunnel surgery (required for patients with Humana commercial coverage only)
- EGD endoscopy (required for patients 59 and younger with Humana commercial coverage only, includes site-of-service evaluation)
- Gastric pacing (required for patients with Humana commercial coverage only)
- Noninvasive home ventilators
- Peripheral revascularization (atherectomy, angioplasty)
- Thyroid surgeries (thyroidectomy and lobectomy)

New medication preauthorization requirements include all medications noted with an asterisk (*) on the preauthorization lists posted on [Humana.com/PAL](https://www.humana.com/PAL).

Find all the details at [Humana.com/new](https://www.humana.com/new).

The Intersection of Health + Care

This past November, we announced our fifth annual release of Humana's value-based-care results that highlight an increase in preventive care, improvement in health outcomes and quality measures, and an overall decrease in cost to Humana's Medical Advantage members. The value-based-care approach is a holistic integrated-care-delivery model centered around primary physicians and their relationship to their patients. More than 83 percent of Medicare Advantage patients live with at least two chronic medical conditions and require coordination of multiple specialists in their care. The value-based-care approach helps balance the assessment of social determinants of health – such as food insecurity, loneliness and social isolation – and looks at how these factors can substantially impact the health of patients.

Written by physicians, this year's Value-based Care Report demonstrates that Medical Advantage patients underwent more preventive screenings, required hospitalization less often and received a higher quality of care demonstrated by HEDIS star ratings. By having access to more resources and information, physicians can focus on patients who need additional support to control their chronic conditions and reduce acute-care episodes. And in this model, with care offered at the right place and the right time, overall costs also were less.

By providing a range of clinical services, such as behavioral health resources, pharmacy services, care coordination and clinical services in the home, with increased data and analytics, we aim to support our physicians as they work to create a better quality of life and well-being for their patients, families, the Medicare population and communities at large.

Humana President and Chief Executive Officer Bruce D. Broussard supports our value-based-care strategy, too. He recently stated, "As Humana continues to improve the functionality of our integrated care strategy with investments in home health and data analytics, we will employ those capabilities to become and even stronger supporters of physician practices as they navigate to value."

View the complete Value-based Care Report at http://valuebasedcare.humana.com/docs/176555_GHHKCYEN_Bklt_4C.pdf?_sm_au_=iHVg5vFmM0122SBE.

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

Help us prevent fraud, waste and abuse

According to a House Ways and Means oversight subcommittee, in 2016, Medicare Advantage had an improper payment rate of 10 percent. This amounted to approximately \$16 billion. When overpayments for standard Medicare are added, the total amount for overpayment is almost \$60 billion.¹

As part of our efforts to improve the healthcare system, Humana has made a commitment to detecting, correcting and preventing fraud, waste and abuse.

Success in this effort is essential to maintaining a healthcare system that is affordable for everyone. Humana has an ongoing nationwide campaign to get the word out about how contracted physicians, other healthcare providers and business partners can help with fraud, waste and abuse detection, correction and prevention.

If you suspect fraud, waste or abuse in the healthcare system, you must report it to Humana and we'll investigate. Your actions may help improve the healthcare system and reduce costs for everyone.

To report suspected fraud, waste or abuse, you can contact Humana in one of these ways:

- Phone: 1-800-614-4126
- Fax: 1-920-339-3613
- Email: siureferrals@humana.com
- Mail: Humana, Special Investigation Unit, 1100 Employers Blvd., Green Bay, WI 54344
- Ethics Help Line: 1-877-5-THE-KEY (1-877-584-3539)

- Ethics Help Line reporting website: www.ethicshelpline.com

You have the option for your report to remain anonymous. All information received or discovered by the Special Investigations Unit (SIU) will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, Humana corporate law department, market medical directors or Humana senior management).

To learn more about Humana's fraud, waste and abuse prevention efforts, visit Humana.com/fraud.

Kristine Bordenave, M.D., FACP, CPMA
Corporate Medical Director

Source: <https://www.publicintegrity.org/2017/07/19/21011/fraud-and-billing-mistakes-cost-medicare-and-taxpayers-tens-billions-last-year>

Changes Announced for 2019 Humana Formularies

Beginning Jan. 1, 2019, certain drugs will have new limitations or will require utilization management (e.g., prior authorization [PA] requirements, step therapy [ST] modifications and nonformulary [NF] changes) under the Humana commercial and Medicare formularies for the 2019 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. Find all the details at Humana.com/new.

Humana Continues Code Editing Software Updates in 2019

As part of its ongoing efforts toward claims process improvements, Humana will continue to update its claims payment systems to better align with correct-coding initiatives, Centers for Medicare & Medicaid Services (CMS) guidelines, national benchmarks and industry standards. Humana posts notifications about upcoming updates the first Friday of every month. Each item notified includes an implementation date for that update.

California physicians and healthcare providers: These updates do not affect any contractual obligation with a contracted independent practice association (IPA). The updates pertain only to participation with Humana's ChoiceCare Network contract.

To view these changes and find additional information about claim policy updates and submitting code-editing questions, visit Humana.com/edits.

Changes Coming to the Preclusion List

Humana will end association with healthcare providers who are affiliated with tax identification numbers or National Provider Identifier numbers (NPIs) on the Centers for Medicare & Medicaid Services (CMS) preclusion list.

The CMS preclusion list includes providers and prescribers who are prohibited from receiving payment for Medicare Advantage (MA) services or Part D drugs prescribed to Medicare beneficiaries. According to the CMS website (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html>), those on the list include individuals or entities who:

- “Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.”

Or

- “Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.”

Beginning Jan. 1, 2019, the preclusion list will be made available to Humana and other Part D sponsors and MA plans. The preclusion will take effect April 1, 2019, and Humana will:

- Reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by a healthcare provider on the preclusion list.
- Deny payment for a healthcare item or service furnished by a healthcare provider or entity on the preclusion list.

For more information about the preclusion list and what it means for healthcare providers, including notification and appeal information, go to the CMS website (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html>).

Look for Humana at a conference near you in 2019

Humana will be attending the following conferences in 2019:

- American Medical Group Association (AMGA), March 27-30, National Harbor, Maryland
- American College of Physicians (ACP), April 11-13, Philadelphia
- Healthcare Financial Management Association (HFMA), June 23-26, Orlando, Florida
- American Academy of Family Practitioners (AAFP), Sept. 24-28, Philadelphia
- Medical Group Management Association (MGMA), Oct. 13-16, New Orleans

Physicians and other healthcare providers are encouraged to mark their calendars for these events. Humana representatives look forward to meeting all types of healthcare practitioners.

Updated Claim Payment Policies Available

Humana publishes its medical claim payment policies online. The information about reimbursement methodologies and acceptable billing practices may help physicians and other healthcare providers and their billing offices bill claims more accurately. This could reduce delays, rebilling and requests for additional information. Find the policies at [Humana.com/ClaimPaymentPolicies](https://www.humana.com/ClaimPaymentPolicies).

Humana recently published two updated policies on the following topics:

- Screening Colonoscopy
 - Medicare Opt-out
 - Modifier 78
 - Modifier EY
-

New and Revised Pharmacy and Medical Coverage Policies Available

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 healthcare organizations.

Information about medical and pharmacy coverage policies can be found at [Humana.com/provider](https://www.humana.com/provider) by selecting "Medical and Pharmacy Coverage Policies" under "Resources." Policies can be reviewed by name or revision date. Users also may search for a particular policy using the search box. More detailed information can be found by reviewing "How to Read a Medical Coverage Policy" and "Understanding the Medical Coverage Policy Development Process" under "Helpful Links."

Recent changes to medical and pharmacy coverage policies are listed below:

New pharmacy coverage policies

- Azedra® (iobenguane I 131)
- Calcitonin gene-related peptide (CGRP) inhibitors
- Epidiolex (cannabidiol)
- Mulpleta (lusutrombopag)
- Nivestym (filgrastim-aafi)
- Nocdurna (desmopressin)
- Onpattro (Patisiran)
- Orilissa (elagolix)

- Poteligeo (mogamulizumab-kpkc)
- Takhzyro (lanadelumab)
- Tibsovo (ivosedinib)

Pharmacy coverage policies with significant revisions

- No revised pharmacy coverage policies

New medical coverage policies

- No new medical coverage policies

Medical coverage policies with significant revisions

- Cardiovascular Disease (CVD) Risk Testing
- Gene Expression Profiling
- Glaucoma Emerging Treatments
- Hyperthermia Treatment for Cancer (local, regional, and whole body)
- Multianalyte Assays with Algorithmic Analyses (MAAAs)
- Neuroablative Techniques for Chronic Pain
- Noninvasive Home Ventilators
- Ocular Surface Disease-Diagnosis and Treatment
- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)
- Serological and Fecal Testing for Inflammatory Bowel Disease (IBD)

Online information Makes It Easier to Do Business with Humana

Humana's "Education on Demand" tool provides physicians, other practitioners and their office staff quick, easy-to-understand information on topics that help simplify doing business with Humana.

This tool can be accessed at <https://www.humana.com/provider/support/on-demand/>.

Available topics are as follows:

- Clinical Quality and Outcomes
- Commercial Risk Adjustment
- Commercial Risk Adjustment Model
- Consult Online (no audio available)
- Go365™
- HumanaAccessSM Visa Card
- Humana Member Summary
- Humana Overview

- Making It Easier for Health Care Providers
- Special Needs Plans (SNPs)

Humana's Making It Easier page includes presentations that can help healthcare professionals better understand Humana's claims policies and processes. The presentations can be accessed at [Humana.com/MakingItEasier \(https://www.humana.com/provider/medical-providers/education/tools/making-it-easier\)](https://www.humana.com/provider/medical-providers/education/tools/making-it-easier).

The page, which will be updated with new content each month, has brief education-on-demand computer-based presentations that include a printable tip sheet with the most important information about each topic. Current topics include:

- Modifiers 96 and 97
- Use of nonspecific procedure codes
- Tools and resources for health care providers
- Home Health Billing
- Chronic Care Management Services
- Primary Diagnosis Codes – Common Errors
- Modifier 25
- Multiple Evaluation and Management (E/M) Services
- Anatomical Modifiers
- Application of Medicare NCD/LCD Guidelines
- Medicare Preventive Services
- Professional Component and Technical Component (PC/TC)
- Humana's Maximum Unit Values
- Drug Testing and Codes
- Humana's Approach to Code Editing
- Modifier 24
- Procedure-to-Procedure Code Editing
- Modifiers 59 and X {EPSU}

Training Available for Secure Online Tools

Humana is phasing out its secure online medical provider portal and offering monthly training sessions for physicians, other healthcare providers and their administrative staff on how to use the Availity Provider Portal instead.

Attendees will learn:

- How to register their organizations for the Availity portal and set up other users
- How to use multipayer tools for common tasks, such as verifying eligibility and benefits, requesting authorizations and checking claim status
- How to use Humana-specific tools on the Availity portal

The overview sessions are led by a Humana eBusiness consultant and include time for questions. There is no cost to attend. Users can sign up at [Humana.com/providerwebinars](https://www.humana.com/providerwebinars).



Learn about Humana's Newest Research

Humana's researchers produce a high volume of peer-reviewed research that is relevant to clinicians and policymakers. These studies support our business strategy, inform programs to improve the health and wellness of the populations Humana serves and provide insights to the larger healthcare world.

Featured research:

With the 2018-2019 flu season upon us, clinicians may be interested to know that Humana data confirms the appropriateness of the high-dose flu vaccine for older adults. In a study presented at the American Public Health Association annual meeting last November, high-dose trivalent vaccine for prevention of flu was more effective than standard-dose trivalent and standard-dose quadrivalent vaccines. View the full research at <http://apps.humana.com/marketing/documents.asp?file=3288402>. View the infographic at <http://apps.humana.com/marketing/documents.asp?file=3300349>.

Check out these other recent publications:

In a Humana comparison of oral with injectable biologic immunotherapies, orally administered medication was associated with more frequent switching to another drug, switching to another route of administration and inpatient admission. The presentation won a Platinum Ribbon at the Academy of Managed Care Pharmacy Nexus meeting in April 2018. View the full research at <http://apps.humana.com/marketing/documents.asp?file=3350451>.

Humana's comparative effectiveness study of anticoagulants for nonvalvular atrial fibrillation (dabigatran, apixaban, and rivaroxaban) yielded mixed findings. View the full research at <http://apps.humana.com/marketing/documents.asp?file=3308760>. An additional investigation concluded that medication persistence did not differ between dabigatran and warfarin after adjusting for demographic factors and clinical characteristics. View the full research at <https://www.ncbi.nlm.nih.gov/pubmed/29808717>.

Humana had a strong presence at the **June 2018 American Diabetes Association Scientific Sessions**. Presented posters documented the rate of return to glucose control after HbA1c levels rose to 8.0 percent (<http://apps.humana.com/marketing/documents.asp?file=3341039>), the association between primary care visit frequency/regularity and noninsulin medication adherence (<http://apps.humana.com/marketing/documents.asp?file=3335176>), the ability of an algorithm for metabolic syndrome to predict progression to diabetes even after adjustment for prediabetes (<http://apps.humana.com/marketing/documents.asp?file=3341026>), and two-year changes in patterns of utilization and cost following participation in a virtual diabetes prevention program (DPP) for older adults (<http://apps.humana.com/marketing/documents.asp?file=3341013>). (NOTE: In an earlier study, the same virtual DPP participants were found to have lower blood sugar and cholesterol levels and experienced meaningful weight loss after one year. View the earlier research at <http://journals.sagepub.com/doi/full/10.1177/0898264316688791>.)

Interested in seeing more research?

Visit Humana's research sites to learn about past research projects, listen to podcasts and view videos that showcase Humana's commitment to research. Access our highlighted research at <http://research.humana.com/> or visit our full research library at <https://www.humana.com/learning-center/research/>.

Ways to connect

Have questions or want to share an idea for other research opportunities? Email Courtney Brown at cbrown37@humana.com.

Physician Toolkits Address Social Determinants

As physicians, we know we must look at the complete picture of a patient. And we are discovering that social determinants of health have a significant impact on our patients' health.

The Centers for Disease Control and Prevention (CDC) defines social determinants (<https://www.cdc.gov/socialdeterminants/>) of health as “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”

Humana researchers, in conjunction with the Robert Wood Johnson Foundation, identified food insecurity and social isolation as two of the most prevalent social determinants affecting health. At Humana, we are focusing on developing innovative strategies and resources to help physician practices address these factors.

Most recently, we have designed simple, effective toolkits aimed at understanding and assessing food insecurity and loneliness in your patients. The toolkits were built on research and include the UCLA three-question screen for loneliness and the Hunger Vital Sign™ two-item screen for food insecurity.

The Food Insecurity Physician Quick Guide (<http://populationhealth.humana.com/documents/quick-guide-to-addressing-food-insecurity.pdf>) and the Loneliness Physician Quick Guide (<http://populationhealth.humana.com/documents/quick-guide-to-addressing-loneliness.pdf>), along with other information and resources on population health, can be found at **PopulationHealth.Humana.com**.

We know that 80 percent of health happens outside the physician's office (<http://www.health3-0.com/patient-centric/other-health-outcome-factors/>), and we're helping physicians and their clinical staff break down barriers to improve patient health.

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

Complete 2018 Compliance Training Today

Reminder to all Humana-participating Medicare, Medicaid and/or dual Medicare-Medicaid providers or provider entities: It's time to complete your 2018 compliance training.

The Centers for Medicare & Medicaid Services and state Medicaid agencies mandate that all physicians and healthcare professionals providing services for a Medicare and/or Medicaid product sufficiently understand compliance program requirements upon initial contract and at least annually thereafter. This includes those contracted with a Humana subsidiary and those who provide administrative support. Humana is required to

confirm your adherence. Related training materials provide direction about state and federal requirements that govern the healthcare industry.

We make it easy for your organization to verify understanding of compliance requirements by offering an online, electronic attestation option via the Availity Provider Portal.

For registered Availity users:

1. Log onto [Availity.com](https://www.availity.com) with an existing user ID and password. (If you have not yet registered for the Availity Portal, go to Availity.com and click “Register,” or view this flyer: [Humana.com/portalregistration](https://www.humana.com/portalregistration). Proceed to Step 2 after you have registered.)
2. Navigate to the “Payer Resources” page, select “Humana” from the list of payers that display in a new window, locate the “Compliance” section and then choose “Humana Compliance Events.”
3. Follow the on-screen instructions to add, review and accept the compliance events until all applicable events show “Complete.”

More information and detailed instructions about using Availity for compliance attestation and to update tax identification numbers and email addresses is available at <http://apps.humana.com/marketing/documents.asp?file=1849705>.

For guidance on completing the compliance attestation or for additional information on this requirement, please refer to [Humana.com/providercompliance](https://www.humana.com/providercompliance). For answers to other questions about compliance, please call Humana provider relations at 1-800-626-2741, Monday through Friday from 8 a.m. to 5 p.m. Central time.

We appreciate our relationship with you and all contracted healthcare professionals.

Kristine Bordenave, M.D., FACP, CPMA
Corporate Medical Director

Note Important Information for Dual-eligible Benefit Coordination

Participating healthcare practitioners who provide medical services to patients with Humana Medicare Advantage (including Value Plus Plan) coverage – some of whom may have dual eligibility – need to be aware of the following information about benefit coordination:

- Medicaid may cover costs and services not covered under the Medicare plan.
- Dual-eligible patients should provide both their Humana ID card and a state-issued Medicaid card.
- For these cost-share-protected patients, physicians and other healthcare providers should submit medical claims to the address on the back of the member ID card for payment of Medicare-covered services.
- For physicians and other healthcare providers who are contracted with Medicaid, any remaining cost must be submitted to Medicaid for review and payment consideration.
- These patients are not responsible for plan-covered:

- Copayments
 - Coinsurance
 - Deductibles
 - Part B drugs
- Any additional cost share for Part A and B services must be submitted to the Medicaid payer.
 - The amount paid by Humana and Medicaid must be accepted as full payment due to the cost-share protection.
 - Patients who are cost-share protected may not be balance-billed.

For questions about Humana plan eligibility and benefits, please refer to Availity.com or call 1-800-457-4708, Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

Humana Offers Guidelines for Working with Dual Eligibles

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage organizations to inform their network physicians and other healthcare professionals about the Medicare and Medicaid benefits and guidelines for patients who are eligible for both Medicare and Medicaid (i.e., dual eligibles).

An overview of the general eligibility and cost-sharing guidelines for Medicaid coverage of dual eligibles can be found at <http://apps.humana.com/marketing/documents.asp?file=3059303>.

Also, physicians and other healthcare professionals who participate in a Humana Medicare HMO network need to complete special needs plan (SNP) training if they are serving Humana-covered SNP patients in one or more of the following locations: Alabama, California, Colorado, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Missouri, Mississippi, Montana, Nebraska, Nevada, New York, North Carolina, Ohio, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Virginia and Washington. The training outlines the responsibilities for physicians and other healthcare professionals related to their patients with Humana SNP coverage, as required by CMS.

CMS requires that the material outlined in the attestation form be reviewed and an attestation form be completed upon hire or contract and annually thereafter. For guidance or additional information about this requirement, please refer to Humana.com/providercompliance. For answers to other questions about compliance, please call Humana provider relations at 1-800-626-2741, Monday through Friday from 8 a.m. to 5 p.m. Central time.

The SNP training can be accessed at Humana.com/eod. Choose “View the 2018 SNP provider training.”

Refer to Humana's Clinical Practice Guidelines

The Agency for Healthcare Research and Quality announced in July that its National Guideline Clearinghouse website, guidelines.gov, is no longer available.

In light of the website's closure, Humana encourages physicians and other healthcare providers to access clinical practice guidelines on Humana.com at <https://www.humana.com/provider/support/clinical/clinical-practice>.

Humana publishes clinical practice guidelines based on guidance from national organizations generally considered experts in their fields. The goal of these updates is to provide timely information about evidence-based best practices to help support patient care and adherence to quality measures.

Training Available for Secure Online Tools

Humana offers monthly training sessions for physicians, other healthcare providers and their administrative staff on how to work with us online.

- Offerings include these webinar topics:
- Working with Humana Online: The Availity Provider Portal
- Authorization and referral management
- Claim status
- Medical records management

The sessions are led by a Humana eBusiness consultant via phone and internet and include time for questions. There is no cost to attend. Users can sign up at [Humana.com/providerwebinars](https://www.humana.com/providerwebinars).

Learn About the Humana Medicare Advantage Peer-to-Peer Review and Provider Dispute Processes

Reminder — Peer-to-peer Review Process Change:

Prior to issuing a medical necessity denial in response to an authorization request, a Humana representative will contact the treating physician or other healthcare provider and offer a peer-to-peer review.

The review must take place prior to Humana's issuance of the denial and within the timeframes specified by the National Committee for Quality Assurance (NCQA) and/or The Centers for Medicare & Medicaid Services (CMS). Additional clinical information may be submitted at any time prior to the peer-to-peer conversation.

Once an initial decision is made, Humana will no longer offer a peer-to-peer review except as part of the dispute process for contracted providers outlined below.

- **Contracted physicians/providers:** If you are unable to complete the peer-to-peer conversation prior to issuance of the denial, you may file a provider dispute (see provider disputes update below). Your Humana-covered patients also may request an appeal.
- **Nonparticipating treating physicians/providers:** If you are unable to complete the peer-to-peer conversation prior to issuance of the denial or the peer-to-peer conversation results in a denial decision, you or your Humana-covered patients may request an appeal.

To ensure a timely and effective review of authorization requests for medical services for patients, physicians and other healthcare providers need to be sure to:

- Submit all relevant medical records and pertinent information to support the authorization request.
- Respond promptly to requests for additional information so a timely and effective review can be completed.

UPDATE — Provider Disputes (Contracted Physicians/Providers Only):

Humana is enhancing the physician/provider dispute process. Beginning on Sept. 24, 2018, Humana is providing the opportunity for a provider dispute prior to the submission of the claim under the following circumstances. As part of this pre-claim dispute, a peer-to-peer conversation may be requested.

- Physician/provider is contracted with Humana.
- Humana's adverse determination was based on lack of medical necessity for an authorization request that was retrospective (retro) or concurrent to the service.
- A peer-to-peer conversation with a Humana medical director did not occur prior to the adverse determination.
- Physicians/providers will have five calendar days from notification of the denied authorization to request the pre-claim dispute.

Questions may be directed to Humana provider customer service at 1-800-457-4708, 8 a.m. to 8 p.m. Eastern time, Monday through Friday.

Work with Humana Online

To access the most up-to-date tools for working with Humana online, physicians, other healthcare professionals and their office staff members can use the Availity Provider Portal. Availity users can:

- Check patient eligibility and benefits

- Submit or manage authorizations and referrals
- Review claim status
- Submit medical records
- Access Humana-specific tools and information

Registration is required. As a multipayer portal, Availity allows you to interact securely with Humana and other participating payers without the need to use multiple systems or remember different user IDs and passwords for each payer.

Additional information

- To learn more, visit [Humana.com/providerselfservice](https://www.humana.com/providerselfservice).
- For training , sign up at [Humana.com/providerwebinars](https://www.humana.com/providerwebinars).

Learn More about Flu Vaccinations

The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months of age and older get an annual flu vaccine.

The 2018 – 2019 trivalent seasonal flu vaccine will cover the three flu strains that research suggests will be most common in the northern hemisphere:

- A/Michigan/45/2015 (H1N1)pdm09-like virus
- A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus
- B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage)

A quadrivalent vaccine also is available that will include the B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage lineage).

Other vaccine details for the 2018 – 2019 flu season:

- Intramuscular (IM) vaccines will be available in trivalent and quadrivalent formulations. All high-dose IM vaccines will be trivalent this season.
- A jet injector can be used for delivery of AFLURIA® for people 18 to 64 years old.

On Feb. 21, 2018, the Advisory Committee on Immunization Practices recommended that the quadrivalent live attenuated influenza vaccine (LAIV4), FluMist, be an option for influenza vaccination of persons for whom it is appropriate for the 2018 – 19 season. The American Academy of Pediatrics has recommended LAIV4 be an option for patients who would not otherwise be vaccinated.

More information about the flu vaccine, including coding guidelines, is available at [Humana.com/new](https://www.humana.com/new). Choose “Flu Vaccinations: A Simple Way to Save Lives.”

Pneumonia Vaccines Protect Children and Seniors

The CDC recommends two pneumococcal vaccines for adults 65 or older: pneumococcal conjugate vaccine (PCV13) and pneumococcal polysaccharide vaccine (PPSV23).

PCV13 also is recommended for:

- All children younger than 5
- Individuals 6 or older with certain long-term health problems or a weakened immune system, including those with sickle cell disease, congenital or acquired asplenia, cerebrospinal fluid leaks and cochlear implants

PPSV23 also is recommended for:

- People age 2 to 64 with certain long-term health problems or a weakened immune system, including:
 - Chronic diseases (e.g., cardiovascular, pulmonary, diabetes, alcoholism, liver disease, etc.)
 - Cerebrospinal fluid leaks or cochlear implants
 - Functional or anatomic asplenia, including sickle cell disease and congenital or acquired asplenia
 - Immunocompromising conditions, such as HIV infection, leukemia, lymphoma, Hodgkin’s disease, kidney failure or organ transplant
 - Individuals currently taking a drug or treatment that lowers the body’s resistance to infection, such as long-term steroids, certain cancer drugs or radiation therapy
- Adults age 19 to 64 who smoke cigarettes or have asthma

More information about the pneumonia vaccine, including coding guidelines, is available at [Humana.com/new](https://www.humana.com/new). Choose “Protect Patients with Pneumonia Vaccines.”

Complete the PAF Online

The electronic practitioner assessment form (ePAF) is an online version of the Humana practitioner assessment form (PAF). The PAF is a comprehensive health assessment form physicians and other healthcare providers can use to help them document vital information for Medicare patients during a face-to-face physical examination.

The ePAF is available now through the Availity Portal. Some advantages of the ePAF are:

- It is fully electronic, meaning no more paper forms to complete.
- It is partially prepopulated, reducing the data elements physicians need to enter.
- It is interactive.
- It is easy to use.

To complete the electronic practitioner assessment form (ePAF), the physician or other healthcare provider should:

1. Access the Humana ePAF through the Availity Provider Portal. Once at the Availity Portal, the physician or other healthcare provider should:
 - A. Log in to the portal using the button at the top right of the screen
 - B. Go to “Payer Spaces” and select Humana
 - C. Select “Applications”
 - D. Select “Open” under “Practitioner Assessment Form”
2. Select a healthcare provider organization.
3. Select a patient from either:
 - E. The physician’s priority queue
 - F. The “Begin Assessment for Patient Not Listed Below” button
4. Examine, evaluate and treat the patient as usual during the face-to-face visit, assessing all chronic and acute health conditions that may be present.
5. Complete the required fields in ePAF.
6. Enter his or her name and credentials on the attestation tab.
7. Click the “Submit” button.
8. Place a copy of the completed assessment in the patient’s medical record or attach it within the electronic medical record (EMR) system.
9. Submit a claim for the patient visit using Current Procedural Terminology (CPT®) code 96160 to indicate a PAF was completed. In addition to 96160, the appropriate office-visit code or evaluation and management (E/M) code should be included on the claim.
 - G. Ensure all appropriate diagnoses are indicated on the claim, coded to the highest level of specificity.
 - H. Ensure all correct coding and claim submission guidelines apply to PAF claims.

Updated Claim Payment Policies Available

Humana publishes its medical claim payment policies online. The information about reimbursement methodologies and acceptable billing practices may help physicians and other healthcare providers and their billing offices bill claims more accurately. This could reduce delays, rebilling and requests for additional information. Find the policies at [Humana.com/ClaimPaymentPolicies](https://www.humana.com/ClaimPaymentPolicies).

Humana recently published two updated policies on the following topics:

- Pass-through billing
 - Telehealth and telemedicine
-

New and Revised Pharmacy and Medical Coverage Policies Available

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 healthcare organizations.

Information about medical and pharmacy coverage policies can be found at [Humana.com/provider](https://www.humana.com/provider) by selecting "Medical and Pharmacy Coverage Policies" under "Resources." Policies can be reviewed by name or revision date. Users also may search for a particular policy using the search box. More detailed information can be found by reviewing "How to Read a Medical Coverage Policy" and "Understanding the Medical Coverage Policy Development Process" under "Helpful Links."

Recent changes to medical and pharmacy coverage policies are listed below:

New pharmacy coverage policies

- Braftovi (encorafenib)
- Jynarque (tolvaptan)
- Kaspargo sprinkle capsule (metoprolol succinate)
- Mektovi (binimetinib)
- Olumiant (baricitinib)
- Palynziq (pegvaliase-pqz)
- Yonsa (abiraterone acetate)

Pharmacy coverage policies with significant revisions

- Antidepressant agents
- Cinryze (C1 esterase inhibitor, human)
- Ruconest (C1 esterase inhibitor, recombinant)

- Xeljanz and Xeljanz XR (tofacitinib)
- Pomalyst (pomalidomide)

New medical coverage policies

- Complementary and alternative medicines

Medical coverage policies with significant revisions

- Comparative genomic hybridization/chromosomal microarray analysis
- Cosmetic surgery, reconstructive surgery, scar revision
- Deep brain stimulation (DBS) and cortical brain stimulation
- Fecal microbiota transplantation
- Fusion imaging
- Gastric pacing
- Genetic testing for cardiac conditions
- Genetic testing for cystic fibrosis
- Genetic testing for disease risk
- Injections for chronic pain conditions
- Obstructive sleep apnea (OSA) and other sleep-related breathing disorders, nonsurgical treatments
- Obstructive sleep apnea (OSA) surgical treatments
- Percutaneous vertebroplasty, kyphoplasty (balloon-assisted vertebroplasty), sacroplasty
- Proton and neutron beam radiation therapy
- Reduction mammoplasty
- Ultraviolet light/laser therapy for skin conditions
- Ventricular assist device (VAD), total artificial heart (TAH)

Online information Makes It Easier to Do Business with Humana

Humana's "Education on Demand" tool provides physicians, other practitioners and their office staff quick, easy-to-understand information on topics that help simplify doing business with Humana.

This tool can be accessed at <https://www.humana.com/provider/support/on-demand/>.

Available topics are as follows:

- Clinical Quality and Outcomes
- Commercial Risk Adjustment
- Commercial Risk Adjustment Model
- Consult Online (no audio available)

- Go365™
- HumanaAccessSM Visa Card
- Humana Member Summary
- Humana Overview
- Making It Easier for Health Care Providers
- Special Needs Plans (SNPs)

Humana's Making It Easier page includes presentations that can help healthcare professionals better understand Humana's claims policies and processes. The presentations can be accessed at [Humana.com/MakingItEasier](https://www.humana.com/provider/medical-providers/education/tools/making-it-easier) (<https://www.humana.com/provider/medical-providers/education/tools/making-it-easier>).

The page, which will be updated with new content each month, has brief education-on-demand computer-based presentations that include a printable tip sheet with the most important information about each topic. Current topics include:

- Modifiers 96 and 97
 - Use of nonspecific procedure codes
 - Tools and resources for health care providers
 - Home Health Billing
 - Chronic Care Management Services
 - Primary Diagnosis Codes – Common Errors
 - Modifier 25
 - Multiple Evaluation and Management (E/M) Services
 - Anatomical Modifiers
 - Application of Medicare NCD/LCD Guidelines
 - Medicare Preventive Services
 - Professional Component and Technical Component (PC/TC)
 - Humana's Maximum Unit Values
 - Drug Testing and Codes
 - Humana's Approach to Code Editing
 - Modifier 24
 - Procedure-to-Procedure Code Editing
 - Modifiers 59 and X {EPSU}
-