~~orn~~

2025 [DB1] ~~43~~ Provider Manual

Humana Healthy Horizons® in Louisiana is a Medicaid P~~p~~roduct of Humana Health Benefit Plan of Louisiana, Inc.

Humana
Healthy Horizons®
in Louisiana

419502LA0324_3LAHLQG9EN _P7374LA0722

Table of contents

Chapter HAPTER I: WelcomeELCOME 5

Louisiana program description 5–6

ChapterHAPTER 2 II: Communicating with Humana Healthy Horizons OMMUNICATING WITH HUMANA 6

Chapter 3HAPTER III: Provider servicesROVIDER SERVICES 7

Primary care providers (PCPs) 7–8

Access to care 8–9

After-hours access 9–10

Integrated telehealth services 10

Women's pPreventative hHealth 10

Family pPlanning 10

Provider information changes 10

Education 11

Provider training 11

Department of Children and Family Services (DCFS) licensing 11

Marketing materials 11

Key contract provisions 12

Adverse incident reporting 12–13

Credentialing and recredentialing 13–15

CAQH application 15

Practitioner credentialing and recredentialing 15

Organizational credentialing and recredentialing—physical health 15–16

Organizational credentialing and recredentialing—behavioral health 16

Provider recredentialing 16–17

Provider rights 17

Provider responsibilities 17

Delegation of credentialing/recredentialing 17

Reconsideration of credentialing and recredentialing decisions

Excluded Providers 17

Provider disputes 17–18

Adverse actions 18

Delegated services, policies and procedures 18–22

Chapter~~HAPTER 4~~IV: Covered services~~OVERED SERVICES~~ 22
General services 22-37
~~Tivity ..... 37~~
Behavioral health ~~and substance use~~ services 38
Screening and evaluation 38
Care management and care coordination 38
Continuation of treatment 38-39
Emergency and non-emergency medical transportation (NEMT) 39
Excluded services 39
Out-of-network care when services are unavailable 39
Sterilization 39-40
Chapter~~HAPTER 5~~V: U~~TILIZATION~~tilization Management ~~MANAGEMENT (UM)~~ 40
Criteria 40
Access to staff 40-41
Referrals 41
Second opinions for non-participating providers 41
Release due to ethical reasons 41
Prior authorization~~s~~s 41-42
Prior authorization time frames 42
Expedited service authorizations 42
Post-authorization 42
Medicaid services requiring prior authorization 42
Services that do not require prior authorization 42-43
Requesting prior authorization 43
Medical and behavioral health services 43
~~Prior authorization for specific oncology services ..... 43-44~~
Retrospective review 44
Continuity of care 44
Louisiana Medicaid Electronic Health Record (EHR) Incentive Payment Program 44-45

Chapter 6~~HAPTER VI~~: Claims and encounter submission, protocols and standards ~~LAIMS AND ENCOUNTER SUBMISSION, PROTOCOLS AND STANDARDS~~ ...45

Medical claims and behavioral health encounters 45

Common submission errors and how to avoid them 45-46

Clean claim~~s~~ submission 46

Clean claim criteria 46

Abortion claim requirements 46

CMS-1500 billing instructions 47

UB-04 Form instructions 47

Claim~~s~~ processing time frames 47

Timely filing 47

Claim~~s~~ overpayments 47

Suspension of provider payment 47

Electronic funds transfer (EFT)/e~~E~~lectronic r~~R~~emittance a~~A~~dvice (ERA) 47–48

To enroll for E~~E~~FT/ ~~electronic remit advice (~~ERA~~) enrollment through Humana~~ 48

Multi-payer EFT/ERA enrollment 48

Incentive plans 48

Claim status 48

Explanation of payment (EOP) 48

Code editing 48–49

Coding and payment policies 49–50

Coordination of b~~B~~enefits (COB~~s~~) 50

Crossover claims 50–51

COB overpayment 51

Recouping payments 51

Member billing limitations 51

Missed appointments 51

Member termination claim processing 51–52

Chapter ~~HAPTER 7VII~~: Reconsiderations, appeals and complaints~~ECONSIDERATIONS, APPEALS AND COMPLAINTS~~ 52

Claim r~~R~~econsiderations 52–53

Claim a~~A~~ppeals 53

Binding a~~A~~rbitration 53

Independent r~~R~~eview 53–54

Provider i~~I~~ssue e~~E~~scalation and r~~R~~esolution 54–55

Louisiana Department of Health (LDH) dispute process 55
Member gGrievance and aAppeal system process 55
Grievance and appeal review timelines 55
Louisiana Medicaid grievance first level review 55
Appeal review timelines 56
Louisiana Medicaid appeal first level l review 56
Expedited appeal process 56
Louisiana Medicaid expedited appeal first level review 56
State fair hearing 56-57

Chapter HAPTER 8VIII: Quality UALITY andAND compliance COMPLIANCE 57
Quality improvement 57
Health records review 57
Healthcare Effectiveness Data and Information Set (HEDIS) 57
Nonstandard supplemental data 57
Standard supplemental data 57
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 57
Occurrences and adverse events reporting 57
Member complaints 57
Maintain a health information system 57
Initiate performance improvement projects (PIPs) 57
Preventive guidelines and clinical practice guidelines 57-58
Quality performance measures 58
Quality Assessment and Performance Improvement (QAPI) program 58
External quality reviews 58
Health record review 58-59
Value-based payment (VBP) programs 59
Compliance and ethics 59
Fraud, waste and abuse policy 59-60

Chapter 9HAPTER IX: Specialized behavioral health PECIALIZED BEHAVIORAL HEALTH 60
Objectives of the behavioral health program 60

Goals of the behavioral health program 60
Integration of behavioral health and medical care ~~pProvider coordination for behavioral health~~ 60
Provider coordination for behavioral health 60–61
Coordination with behavioral health care management 61
Continuity of care for behavioral health 61

Addiction 61
Recovery 61–62
Treatment 62
Disclosures 62
Provider expectations regarding Office of Juvenile Justice and DCFS coordination~~Provider expectations regarding Office of Juvenile Justice (OJJ) and Department of Children and Families (DCFS)~~ 62
Payment for services provided to CSoC recipients 62
Act 503 63
Individuals providing services 63
Provider quality monitoring program for specialized behavioral health providers 63
~~Provider network monitoring ..... 64~~
Applied b~~B~~ehavioral a~~A~~nalysis (ABA) q~~Q~~uality m~~M~~onitoring r~~R~~eview 64
Provider network monitoring 64
Behavioral Health Fidelity Monitoring Plan for evidence-based programs 65

Chapter ~~9~~10~~HAPTER X~~: Member enrollment and eligibility ~~EMBER ENROLLMENT AND ELIGIBILITY~~ 65

Medicaid eligibility 65
Newborn enrollment 65
New member kits 65
Member ID cards 66
Automatic ~~primary care physician (~~PCP~~)~~ assignment 66
Monitoring PCP reassignment 66
Disenrollment 67
Automatic renewal 67
Referrals for release due to ethical reasons 67
Member support services benefits 67
Member services 67
24-hour nurse advice line 67–68
Emergency behavioral health services 68
24-hour b~~B~~ehavioral health crisis hotline 68

Chapter ~~HAPTER~~ 11~~XI~~: Member rights and responsibilities ~~EMBER RIGHTS AND RESPONSIBILITIES~~ 68

Personally identifiable information (PII) and protected health information (PHI) 69

Member privacy 69

Member consent to share health information 69–70

LDH requirements regarding 24/7 PCP coverage 70

Americans with Disabilities Act (ADA) 70

Cultural competency 70–71

Advance directives 71

Mental health advance directive 71

Chapter 12~~HAPTER XII~~: Care management programs ~~ARE MANAGEMENT PROGRAMS~~ 71

Care Management 71

Referrals 71–72

Intensive care management for high-risk members 72

Care management for medium-risk members 72

Care management for low-risk members 72

Transitional care management 72

HumanaBeginnings® prenatal program 72

Chapter 13~~HAPTER XIII~~: Population health programs and incentives ~~OPULATION HEALTH PROGRAMS AND INCENTIVES~~ 72

Go365 for Humana Healthy Horizons® 73

Interpreter services 74

Health education 75

Chapter 14~~HAPTER XIV~~: Value-added~~ALUE ADDED BENEFITS~~ benefits 75

Chapter 15~~HAPTER XV~~: Pharmacy~~HARMACY~~ 77

Utilization Management 77

Coverage limitations 77

Immunizations 77

Copay 77–78

Pharmacy lock-in program 78

Over-the-counter (OTC) ~~h~~Health and w~~W~~ellness 78

Referrences 99

Appendix~~PPENDIX~~: LDH clean~~CLEAN~~ claim ~~CLAIM SAMPLES~~ samples 79–86

ChapterHAPTER 1: WelcomeELCOME

Thank you for becoming a participating provider with Humana Healthy Horizons® in Louisiana. (Humana). We feel honored to serve the people of the Pelican State. Humana has served Louisiana families, including seniors and veterans, for a long time.

We are a community-based health plan that serves Medicaid consumers members throughout Louisiana. We strive to support participating physicians and other healthcare providers because we believe strong collaborations help facilitate a high quality of care and a respectful member experience.

As a mManaged cCare oOrganization (MCO), Humana Healthy Horizons strives to improve the health of our members by utilizing an integrated, contracted network of high-quality providers. Network primary care providers (PCPs) not only provide a range of services themselves, including preventive healthcare and coordinated patient care, but they also refer patients to specialists, to ensure timely access to appropriate preventive healthcare services.

In this manual, you can easily find information about:

- Covered services
- Member eligibility
- Prior authorizations
- Claims and encounter submission
- Provider responsibilities
- Quality and compliance
- Care management
- Population health programs and incentives
- Grievances and appeals

Humana Healthy Horizons in Louisiana distributes its member rights and responsibility statements to the following groups upon enrollment and annually thereafter:

- New members
- Existing members
- New providers

Existing providers: If If you have questions or need help, go tovisit Humana.com/HealthyLA or call us at 1-**800-448-3810 (TTY: 711)**.

Thank you for partnering with Humana Healthy Horizons in Louisiana to improve the health and well-being of the Louisiana community.

Louisiana program description

The mission of the Louisiana Department of Health (LDH) is to protect and promote health for all Louisiana residents by ensuring access to needed medical, preventive and rehabilitative services. LDH is dedicated to fulfilling its mission through the direct provision of quality services,

the development and stimulation of services of others, and the utilization of available resources in the most effective manner.

As of February 2022December 2023, more than 1.68 million Louisiana residents were enrolled with an Managed Care Organization (MCO). Most recently, the state has experienced dramatic improvements in health metrics due to an expansion of MCO enrollment. Also, importantly, Medicaid members are more engaged in care.

Guided by the Institute for Healthcare Improvement's Triple Aim initiative, the LDH partners with members, providers and high-performing health plans to build a Medicaid managed care delivery system that improves the health of populations (better health), enhances the experience of care for individuals (better care), and effectively manages Medicaid per-capita care costs (lower costs). Humana Healthy Horizons' in Louisiana's contract to provide services to Louisiana Medicaid beneficiaries underscores its support of Louisiana's ongoing Triple Aim focus.

Humana Healthy Horizons in Louisiana has the expertise, competencies and resources to achieve the following objectives:

- Advance evidence-based practices, high-value care and service excellence

- Support innovation and a culture of continuous quality improvement
- Ensure ready member access to care
- Improve member health
- Initiate a decrease in fragmentation and an increase in integration across provider and care settings, particularly for members with behavioral health needs
- Use a health information technology-supported approach to population health that's designed to:
  - Mmaximize member health
  - Aadvance health equity
  - Aaddress priority social determinants of health (SDOH), which include housing, food insecurity, physical safety and transportation
- Facilitate a straightforward decrease in administrative burden for providers and members
- Align financial incentives for MCOs and providers, per the LDH guidelines
- Build shared capacity to improve healthcare quality through data and collaboration
- Strive for a reduction of wasteful spending, abuse and fraud

Adoption of Medicaid pPolicies and pProcedures

According to Louisiana Act 319, any policy or procedure proposed by Humana Healthy Horizons cannot be implemented until it is approved by LDH after the public has a chance to comment (during a 45-day public comment period). The aAct considers a "policy and procedure" to include any guidelines describing:

- Bbilling
- Mmedical management and utilization review
- Ccase management
- Cclaims processing
- Ggrievances and appeals
- Ootther guidelines or manuals

In extreme situations (imminent peril to the public health, safety, or welfare), LDH can forego the 45-day public comment period. Otherwise, both LDH and Humana Healthy Horizons are prohibited from enforcing any policy or procedure that is not adopted in compliance with the public comment period and procedures detailed in Act 319.

ChapterHAPTER 2II: Communicating with Humana Healthy HorizonsOMMUNICATING WITH HUMANA

By phone (all operating hours in local time):

Provider and Medicaid mMember sServices: 1-800-448-3810 (TTY: 711),

Monday through – Friday, 7 a.m. – 7 p.m., Monday – Friday

24-hour Nurse Advice Line (24/7/365): 1-800-448-3810 (TTY: 711)

24-hour Behavioral Health Crisis Line (24/7/365): 1-

844-461-2848

Clinical Intake Team (CIT) for medical procedures and behavioral health: 1-800-448-3810 (TTY: 711),
7 a.m. – 7 p.m., Monday – Friday

Care management: 1-800-448-3810 (TTY: 711), 8 a.m. – 5 p.m., Monday – Friday
8 a.m. – 5 p.m., Monday – Friday

Prior authorization for physician provider-administered medications: 1-866-461-7273

Prior aAuthorizations for medications on the Preferred Drug List (-

PDL): 1-800-424-1664

Member grievances and appeals: 1-800-448-3810 (TTY: 711); 7 a.m. – 7 p.m., Monday – Friday

Provider complaints: 1-800-448-3810 (TTY: 711); 7 a.m. – 7 p.m., Monday – Friday

Availity Essentials™ customer service/tech support: 1--800-282-4548; 78 a.m. – 78 p.m., Monday – Friday

Ethics and compliance concerns: 1-877-5-THE-KEY (584-3539)

~~(877-584-3539)~~

Louisiana Medicaid Fraud and Abuse Hotline: 1-

800-488-2917 ~~(TTY: 1-800-220-5404)~~

Humana fraud, waste and abuse reporting: 1-

800-614-4126

By mail:

Claims
Humana Inc.
P.O. Box 14601
Lexington, KY 40512-4601

Provider Correspondence
P.O. Box ~~14822~~14601
Lexington, KY 40512-4601~~4822~~

Member g~~G~~rievances and a~~A~~ppeals
P.O. Box 14546
Lexington, KY 40512-4546

Fraud, w~~W~~aste and a~~A~~buse
1100 Employers Blvd.
Green Bay, WI 54344

Provider c~~C~~omplaints
Attn: Provider Relations
1 Galleria Blvd., Suite 1000
Metairie, LA 70001-2081

~~P.O. Box 14822~~
~~Lexington, KY 40512-4822~~ Helpful websites

Humana.com

Humana Healthy Horizons has created a website specific to Louisiana Medicaid containing resources and updates for providers, viewable at Humana.com/HealthyLA.

Providers also may obtain plan information from Humana.com/providers. This information includes ~~, but is not limited to,~~ the following:

- Health and wellness programs
- Clinical p~~P~~ractice g~~G~~uidelines (CPGs)
- Provider publications (including handbooks, newsletters and~~,~~ program updates)
- Pharmacy services
- Claim resources
- Quality resources

For help or more information regarding web-based tools, visit our secure provider portal at Availity Essentials~~.com~~.

Provider portal
Humana Healthy Horizons ~~has partnered~~partners with Availity Essentials to give providers access to member and claim data for multiple payers ~~using one login~~all in one place. Availity Essentials offers access to:

- Member eligibility and benefits
- Prior authorizations
- Claim status
- Claim submission
- Appeal~~s~~ and dispute~~s~~ submission
- Remittance advice
- Staff rosters of credentialed and contracted providers of mental health rehabilitation services

- Education and training materials including the Humana Healthy Horizons Louisiana Medicaid provider manual
- Member MCO care plans and health needs assessments

To learn more, call 1-**800-282-4548** or visit Availity Essentials.com.

ChapterHAPTER 3III: Provider servicesROVIDER SERVICES

Primary care providers (PCPs)

The PCP shall serve as the member's initial and most important point of interaction with the the contractor'sHumana Healthy Horizons in Louisiana provider network. A PCP shall be an individual physicianproviderphysician, nurse practitioner or physician providerphysician assistant [FB2][DB3]who accepts primary responsibility for the management of a member's healthcare. The PCPprimary care provider is the member's point of access for preventive care or an illness and may treat the member directly, refer the member to a specialist (secondary/tertiary care), or admit the member to a hospital.

- All Humana Healthy Horizons in Louisiana members choose or are assigned to a PCP on enrollment in the plan. PCPs help facilitate a "medical home" for members. This means that PCPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners. PCPs also are required to know how to screen and refer members for behavioral health conditions.
- For more information, Pplease refer to Chapter 3 Provider Servicesthis chapter, and also Chapter 4: Covered sServices, and the bBehavioral health and substance -use services subsection., for more information.

Members select a PCP from our health plan's provider directory. Members have the option to change to another participating PCP with cause as often as needed. Members initiate the change by calling member services. PCP changes are effective on the first day of the month following the requested change.

PCPs shall:

- Be responsible for supervising, coordinating and providing initial and primary care to members
- Be responsible for initiating referrals for specialty care
- Be responsible for maintaining the continuity of patient care 24 hours a day, seven 7 days a week
- Have hospital admitting privileges or a formal referral agreement with a primary care providerPCP who has hospital admitting privileges

In addition, Humana Healthy Horizons in Louisiana PCPs play an integral part in coordinating healthcare for our members by providing:

- Availability of a personal healthcare practitioner to assist with coordinating a member's overall care, as appropriate for the member
- Continuity of the member's total healthcare
- Early detection and preventive healthcare services
- Elimination of inappropriate and duplicate services

PCP care coordination responsibilities include, at a minimum, the following:

- Treating Humana Healthy Horizons in Louisiana members with the same dignity and respect afforded to all patients — including high standards of care and the same hours of operation.
- Managing and coordinating the medical and behavioral healthcare needs of members to ensure all medically necessary services are made available in a timely manner.
- Referring patients to subspecialists, and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available, and; communicating with all other levels of medical care to coordinate and follow up the care of individual patients
  - For providers seeking assistance in finding a specialist for their patients, please email LAMCDSDOH@humana.com.
- Providing the coordination necessary for referring patients to specialists.
- Maintaining a medical record of all services rendered by the PCP and a record of referrals to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care.
- Developingment of plans of care to address risks and medical needs and other responsibilities as defined in this section.
- Ensuring that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 C.F.R. Parts 160 and 164 and all state statutes
  - 45 C.F.R. Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information.

- Providing after-hours availability to patients who need medical advice
  - At a minimum, the PCP office shall have a return-call system staffed and monitored to ensure that the member is connected to a designated medical practitioner within 30 minutes of the call.

- Working with MCO care managers to develop plans of care for members receiving care management services.
- Participating in the MCO's care management team, as applicable and medically necessary.
- Conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/adverse childhood experiences (ACEs), substance use, early detection, identification of developmental disorders/delays, social-emotional health, and social determinants of health (SDOH) to determine whether the member needs behavioral health services or linkages to community-based organizations to address SDOH
- Consulting with behavioral health BH specialists to ensure basic behavioral health BH services are available in the primary care setting.
  - PCPs can contact the Humana Healthy Horizons in bLA BBehavioral hHealth mMedical dDirector by sending a request for consultation via encrypted email to: LAMCDCaseManagement@humana.com with the sSubject lLine to read: "BH Consult Request." The request is toshould include member name, Medicaid ID, reason for consult, and PCP contact information.
  - PCPs can utilize the Provider to Provider Consultation Line (PPCL) for questions related to pediatric or perinatal mental health.
    - 1. First, Rregister for the PPCL by completing theat Registration Form (la.gov). docs.google.com/forms/d/e/1FAIpQLSced56_16F_f9W4HlQqRmyYpw92xw-rvJaBnoFqlDW8SMk8qg/viewform
    - 2. Then, Ccall **1-(833-)-721-2881** or mail ppcl@la.gov for a helpconsult. A mMental hHealth cConsultant will respond to questions about behavioral health and local resources. The consultanty can connect you to one of the on-call psychiatrists to assist with diagnostic clarification and medication management questions.
- Maintaining continuity of the member's healthcare.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, seven 7 days a week.
- Making referrals for specialty care and other medically necessary services, both in- and out -of -network, if such services are not available within the Humana Healthy Horizons network.
- Following all referral and prior -authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of Humana Healthy Horizons in Louisiana and the LDH as outlined in this manual.
- Discussing advance medical directives with all members as appropriate.
- Providing 30 days of emergency coverage to a Humana Healthy Horizons in Louisiana-covered patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, in-patient history and documentation of all PCP and specialty care services, etc., in a complete and accurate medical record that meets or exceeds the Department of Medicaid Services'Louisiana Department of Health's specifications.
- Obtaining patient records from facilities visited by Humana Healthy Horizons patients for emergency or urgent care, if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use.
- Referring members to behavioral healthcare providers and arranging appointments, when clinically appropriate.
- Assisting with coordination of the member's overall care, as appropriate. for the member.
- Serving as the ongoing source of primary and preventive care, including Eearly and Pperiodic Sscreening, Ddiagnostic and Ttreatment (ESPSDT) for persons younger than 21.
- Recommending referrals to specialists, as required.
- Participating in the development of care management and treatment plans and notifying Humana Healthy Horizons of members who may benefit from care management.
- Maintaining formalized relationships with other PCPs to refer their members for after-hours care, during certain days, for certain services or other reasons to extend their practices.
- Understanding and agreeing that provider performance data can be used by Humana Healthy Horizons in Louisiana.
- Understanding that all network hospitals are required to comply with the data submission requirements of tLouisianaa Revised Statues.S. 40:1173.1 through 1173.6. including, but not limited to, syndromic surveillance data under the Sanitary Code of the sState of Louisiana (LAC 51:II.105)
  - The MCO shall encourage the use of hHealth iInformation eExchanges (HIEs) whenre direct connections to public health reporting information systems are not feasible or are cost prohibitive.

Access to care

Participating PCPs and specialists are required to ensure adequate accessibility to healthcare 24 hours a day, ~~seven~~ 7 days a week and shall not discriminate against members. Members should be triaged and provided appointments for care within the time frames below.

Medical cCare:

Provider/fFacility tType	Standard
Emergencies and uUrgent cCare	
Emergency cCare	24 hours, 7 days/week within 1 hour of request
Urgent nNon-emergency cCare	24 hours, 7 days/week within 24 hours of request
Primary cCare	
Non-Uurgent sSick	Within 72 hours
Non-Uurgent rRoutine	6 weeks
After-hHours, by phone	Answer by live person or call -back from a designated medical practitioner within 30 minutes
Prenatal vVisits	
1st tTrimester	14 days
2nd tTrimester	7 days
3rd tTrimester	3 days
High-risk pregnancy, any trimester	3 days
Family pPlanning	1 week
Specialty cCare	
Specialist aAppointment	1 month
Waiting rRoom	
Scheduled aAppointments	< 45 minutes
tTime	
Accepting nNew pPatients	
PThe practitionerovider r[CC4][DB5] office is open to new patients	Provider is listed in directory and/or registry file as open

Behavioral hHealth care:

Provider/fFacility tType	Standard
Specialized bBehavioral hHealth pProviders	
Emergency c Care	24 hours, 7 days/week within 1 hour of request
Nonu-Urgent rRoutine	14 days
Urgent nNon-emergency cCare	48 hours
Waiting rRoom tTime, scheduled appointments	< 45 minutes
Psychiatric iInpatient hHospital (emergency involuntary)	4 hours
Psychiatric iInpatient hHospital (involuntary)	24 hours
Psychiatric iInpatient hHospital (voluntary)	24 hours
American Society of Addictionve Medicine (ASAM) lLevels 3.3, 3.5 and& 3.7	10 business days
Withdrawal mManagement	24 hours when medically necessary
Psychiatric rResidential tTreatment fFacility (PRTF)	20 calendar days

After-hours access

When members call requesting urgent care appointments and your office is unable to schedule within 24 hours, refer them to an urgent care center.

You ~~are~~ also are expected to:

- Request healthcare insurance information and verify member eligibility before rendering service
  - ~~.~~You can verify member eligibility and obtain information for other healthcare insurance coverage we have on file by accessing the provider portal at Availity Essentials~~.com;~~.
- Visit members daily when admitted ~~n admitted~~ as inpatients to an acute care facility~~;~~.
- Have a system in place for following up with patients who miss scheduled appointments~~.; and~~
- Treat members with respect
  - ~~;~~Humana Healthy Horizons members should not be treated differently than patients with other healthcare insurance.

~~Integrated telehealth services~~[CC6][DB7]

~~Members have 24/7 access to urgent care, behavioral health services and psychiatric consults via virtual urgent care, 24 hours a day, 7 days a week.. Through this program, licensed healthcare professionals diagnose and treat common ambulatory issues and help members manage chronic and behavioral health conditions.~~

Women's p~~P~~reventa~~at~~ive h~~H~~ealth

Humana Healthy Horizons ~~in Louisiana will~~ provides coverage for ~~one (~~1~~)~~ well-woman gynecological examination per year, with no pre-authorization or referral required, for women 21 years and older, when performed by the member's PCP or in-~~-~~network gynecologist. This is in addition to ~~one (~~1~~)~~ preventa~~at~~ive medicine visit for adults age~~d~~ 21 ~~years~~ and older. This is to allow women access to the gynecological components of annual preventa~~at~~ive screening visits and is not to be considered duplicative service. The well-women visit includes~~:~~ an examination, lab work, sexually transmitted infection (STI) screening, a mammogram~~s~~ (members age~~d~~ 40 and older), a Pap test (annually for members age 21 and over)~~,~~ and ~~Contraceptive~~ contraceptive methods and counseling, as ~~age~~ appropriate.

A r~~R~~outine Pap test~~ing~~ for members under the age of 21 is not covered. A Pap test~~ing~~ for members under age 21 will be considered medically necessary when the following criteria are~~is~~ met:

- Were exposed to diethylstilbestrol before birth~~;~~
- Have ~~human immunodeficiency virus~~HIV~~;~~
- Have a weakened immune system~~;~~
- Have a history of cervical cancer or an abnormal cervical cancer screening test~~; or~~
- Meet other criteria subsequently published by the American College of Obstetricians and Gynecologists (~~-~~ACOG)~~.~~

For members under age 21, the treating provider must submit the required documentation ~~needed~~ for billing to the laboratory provider.

Louisiana Medicaid allows payment for one screening mammogram (either film or digital) per calendar year for beneficiaries meeting one or more of the following criteria:

- Any woman age 30 or older with hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation.
- Provider recommendation for any woman 35 years of age or older with a predicted lifetime risk greater than 20 percent.
- Any woman who is 35 through 39 years of age.
  Please note: Only one baseline mammogram is allowable between this age range for beneficiaries not meeting other criteria.
- Any woman who is 40 years of age or older.

Family p~~P~~lanning

Members, including adolescents, may receive family planning services and related supplies from appropriate Medicaid family planning providers regardless of network status ~~,~~(participating or non-participating). These services do not require a referral or prior authorization.

The~~se~~ services include:

- A c~~C~~omprehensive medical history and physical exam at least once per year. This visit includes anticipatory guidance

and education related to the member's reproductive health/needs~~.~~;

- Contraceptive counseling (including natural family planning), education, follow-up visits and referrals~~.~~
- Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health~~.~~;
- Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the ~~Federal~~ U.S. Food and Drug Administration (FDA)~~.~~;
- Drugs for the treatment of lower genital tract and genital skin infections/disorders~~,~~ and urinary tract infections~~,~~ when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/ encounter for the treatment/drugs also may ~~also~~ be covered~~.~~;
- Male and female sterilization procedures provided in accordance with 42 C~~.~~F~~.~~R. Part 441, Subpart F~~;~~
- Treatment of major complications from certain family planning procedures such as~~:~~ treatment of a perforated uterus due to intrauterine device insertion~~,~~; treatment of severe menstrual bleeding caused by a medroxyprogesterone acetate injection requiring dilation and curettage~~,~~; and treatment of surgical or anesthesia-related complications during

a sterilization procedure.;

- Transportation services to and from family planning appointments provided all other criteria for nNone-Emergency mMedical tTransportation (NEMT) are met.
- Diagnostic evaluation, supplies, devices and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection, or treatment of ~~sexually transmitted infections (~~STIs~~)~~
  - ~~.~~Prior authorizations is not required for the treatment of STIs.
- Age-appropriate vaccination for the prevention of HPV and cervical cancer.

~~- Insertion and removal of all FDA approved long-acting reversible contraceptives.~~
~~- Long-acting reversible contraceptive (LARC) devices are covered when provided in the postpartum period prior to discharge. Hospitals shall bill for LARC device separately from the inpatient stay.~~
~~- Reimbursement for LARC devices inserted in the outpatient hospital setting is in addition to the outpatient hospital reimbursement. Hospitals shall bill the DME revenue code of 290 with the appropriate HCPCS code for the LARC device on the UB-04.~~

Provider information changes

Advance written notice is required for status changes, such as a change in address or, phone number or adding or deleting a provider at your practice. The information is critical to the clean processing of your claims, ensures our provider directories are current and reduces unnecessary calls to your practice. ~~The information is reportable to Medicaid and Medicare.~~

Practitioners are strongly encouraged to provide their language, race and ethnicity for[CC8][DB9] Humana Healthy Horizons ~~in Louisiana~~ to reference when ~~a~~ members calls requesting ~~a~~ practitioners with the same race, ethnicity, and language as themselves.

Education

Humana Healthy Horizons ~~in Louisiana~~ will conduct an initial educational orientation (either online or in -person) for all newly contracted providers within 30 days of activation. Providers receive periodic and/or targeted education as needed.

Provider training

Providers are expected to ~~adhere to~~comply with all training ~~programs~~ requirements identified as compliance-based by the contract and Humana Healthy Horizons ~~in Louisiana~~. This includes agreement and assurance that ~~training~~ all affiliated participating providers and staff members ~~receive training regarding the identified compliance material~~comply with required training.

Providers must complete annual compliance training on the following topics as required by Ssection 6032 of the fFederal Deficit Reduction Act of 2005:

- General cCompliance (Ethics Every Ddday and cCompliance policy)
- Fraud, waste and abuse
- Medicaid provider orientation and training
- Cultural competency
- Health, safety and welfare (abuse, neglect and exploitation)

Note: An attestation at the organization level must be submitted annually to us to certify that your organization has a plan in place to comply with and conduct training on required Medicaid ~~required~~ topics.

~~The t~~Training on the topics outlined above is designed to ensure the following:

- Sufficient knowledge of how to effectively perform the contracted function(s) to support members of Humana Healthy Horizons ~~in Louisiana~~
- The presence of specific controls to prevent, detect and/or correct potential, suspected or identified noncompliance and/or fraud, waste or abuse

All new providers also ~~also will~~will ~~also~~ receive Humana~~'s~~ Healthy Horizons' ~~in Louisiana~~ Medicaid provider orientation.

Providers and their office staff ~~members~~ can access these online training modules 24 hours a day, 7 days a week, ~~24/7~~ at Humana.com/P~~p~~roviderCcompliance.

For additional provider training, v~~:~~ Visit ~~w bpt and iw~~Provider portal webinars and resources. ~~Humana.com/providers, select Medical Resources and choose "Web-based Training Schedule" under "Education and News."~~

Department of Children ~~and~~ and& Family Services (DCFS) licensing

Participating providers must comply with DCFS licensing requirements as applicable and submit proof of compliance upon Humana Healthy Horizons' ~~in Louisiana's~~ request.

Marketing materials

Marketing materials will not be distributed through Humana Healthy Horizons' ~~in Louisiana's~~ provider network.

Distribution of branded health education supplies will be limited to Humana Healthy Horizons ~~in Louisiana~~ members and not available to those visiting the provider's facility. Such branded health education materials shall not provide enrollment or disenrollment information.

Healthcare providers may not solicit enrollment or disenrollment in an MCO or ~~to~~ distribute MCO-specific materials as a marketing activity.

Participating providers may:

- Let their patients know of their affiliations with participating MCOs and list each MCO with which they have contracts~~.~~
- Choose whether to display and/or distribute health education materials for all contracted MCOs~~.~~

Health education materials shall adhere to the following guidance:

- Posters cannot be larger than 16 by 24 inches.
- Children's books ~~that are~~ donated by MCOs must be in common areas.
- Materials may include the MCO's name, logo, phone number and website.
- Providers are not required to distribute and/or display all health education materials provided by MCOs with which they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable.

Providers can display MCO marketing materials (provided that appropriate notice is conspicuously and equitably posted in both material size and typeset) for all MCOs with which ~~the provider~~they are ~~is~~ contracted according to the following:

- If providers choose to display MCO participation stickers, they must display stickers by all contracted MCOs.
- Provider MCO p~~P~~articipation stickers cannot be larger than 5 by 7 inches or include any information other than the MCO name and/or logo or with the statement of facility acceptance.

Providers can inform their patients of the benefits, services and specialty care services offered through the provider's participating MCOs. However, providers shall not:

- Recommend one MCO over another
- Offer patients incentives for selecting one MCO over another
- Assist the patient in deciding to select a specific MCO in any way, or otherwise intend to influence a member's decision~~.~~

Upon MCO contract termination, ~~a~~ providers who haves contracts with other MCOs may notify their patients of the status change (including the termination date) and the impact of such a change on ~~the~~ patients. Providers shall continue to see patients currently enrolled in the MCO until the contract is terminated according to all terms and conditions.~~Providers shall continue to see current patients enrolled in the terminated MCO until the contract is terminated according to all contract terms and conditions.~~

Key contract provisions

To make it easier for you, we have outlined key components of your contract with Humana Healthy Horizons ~~in Louisiana~~.

These contract elements strengthen our relationship with you and enable us to meet or exceed our commitment to improve the healthcare and well-being of our members. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of our members.

In compliance with the Affordable Care Act and the 21st~~st~~ Century Cures Act, federal law requires that states screen and enroll providers~~,~~ therefore, all providers who order, prescribe, refer, provide services~~,~~ or seek prior authorization for services for Humana Healthy Horizons members must enroll in Medicaid through the p~~P~~rovider e~~E~~nrollment p~~P~~ortal ~~at https://www.lamedicaid.com/provweb1/default.htm~~. If enrollment cannot be validated or ~~it~~ is incomplete, providers risk not being paid. Providers ~~that~~who are unsure of their enrollment status or ~~that~~ want to check their status ~~of providers~~ may use the p~~P~~rovider p~~P~~ortal e~~E~~nrollment l~~L~~ookup t~~T~~ool ~~https://www.lamedicaid.com/portalenrollmentstatus/search~~. Results will show the provider's status as either enrollment complete, action required, application not submitted~~,~~ or currently in process. Providers ~~that are~~ not shown in the results are not required to enroll at this time. Invitation letters for those providers will be sent at a later date. The l~~L~~ookup t~~T~~ool is updated daily.~~-~~

Providers needing assistance with application and enrollment should contact Gainwell Technologies by emailing LouisianaProvEnroll@gainwelltechnologies.com or ~~contacting~~calling **1-833- 641-2140** for a status update on enrollment and any next steps needed to complete the process.

Unless otherwise specified in a provider's contract, the following standard key contract terms apply. Participating providers are responsible for:

- Providing Humana Healthy Horizons ~~in Louisiana~~ with advance written notice of intent to terminate an agreement with us. Notice must be given at least 90 days prior to the date of the intended termination and submitted on your organization's letterhead~~.~~
- Sending the required 60-day notice if you plan to close your practice to new patients. If we are not notified within this time period, you will be required to continue accepting Humana Healthy Horizons ~~in Louisiana~~ members for a 60-day period following notification~~.~~
- Providing 24-hour availability to your Humana Healthy Horizons ~~in Louisiana~~ -covered patients by telephone (for PCPs only). Whether through an answering machine or a taped message used after hours, patients should be provided the means to contact their PCP or a back~~-~~up ~~physician~~ provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back~~-~~up ~~physician~~ provider and only recommends emergency room (ER) use for after hours~~.~~
- Submitting claims and corrected claims within 365 calendar days of the date of service or discharge~~.~~
- Filing appeals within 180 calendar days of the date of service or discharge~~.~~
- Keeping all demographic and practice information up to date~~.~~
- Posting notices of non~~-~~discrimination in conspicuous places so ~~that it~~the information is available to all employees and applicants~~.~~

Per our agreement with LDH, Humana Healthy Horizons' ~~in Louisiana's~~ claim processing responsibilities include:

- Processing to either pay or deny a clean claim within 30 calendar days of receipt of the claim~~.~~
- ~~Processing all claims, including pended claims, within 60 calendar days of receipt of the claim.~~
-

- Paying or denying all (100%) pended claims within 60 calendar days of the date of receipt.
- Providing you with an appeals procedure for timely resolution of requests to reverse a Humana Healthy Horizons in Louisiana determination regarding claim payment.
  - Our appeal process is outlined in the "Appeals and gGrievances" and Appeals section of this manual.
- Offering a 24-hour nurse triage phone service for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance, up to our allowable rate for covered services
  - .If the member's primary insurance pays a provider equal to or more than the Humana Healthy Horizons in Louisiana fee schedule for a covered service, Humana Healthy Horizons in Louisiana will not pay any additional amount.
  - If the member's primary insurance pays less than the Humana Healthy Horizons in Louisiana fee schedule for a covered service, Humana Healthy Horizons in Louisiana will reimburse the difference up to the plan's allowable rate.

These are just a few of the specific terms of our agreement. We expect participating providers to follow industry- standard -practice procedures even though they may not be spelled out in our provider agreement.

Adverse incident reporting

~~Humana Healthy Horizons in Louisiana will assess, investigate, report, and follow-up on all adverse incidents involving the specialized behavioral health population, including:~~

- ~~Specialized Behavioral Health providers are required to complete and submit reports of an adverse incident to Assuring the member is protected from further harm and that medical or other services are provided, as needed~~
- ~~Following up to determine cause and details of the critical incident if a provider agency or staff member is involved~~
- ~~Identifying possible measures to prevent or mitigate the reoccurrence of similar critical incidents; and~~
- ~~Monitoring the effectiveness of remedial actions when a provider agency or staff member is involved~~

Humana Healthy Horizons that involve members of the Specialized Behavioral Health population within ~~in Louisiana will assure~~ ensure providers complete and submit adverse incident reports within ~~one~~ 1 business day of discovery of the incident on the state mandated form. This state mandated form will have instructions for how to submit the form to Humana Healthy Horizons.[CG10][DB11]

~~If appropriate,~~ ~~[CG12][DB13]~~Humana Healthy Horizons Specialized Behavioral Health providers ~~in Louisiana and providers~~ must report allegations of abuse, neglect, exploitation, ~~or~~ extortion, or death directly and immediately to the appropriate protective services or licensing ~~agency or licensing~~ agency[CG14][DB15]. The following agencies are responsible for investigating such allegations:

- ~~Department of Child and Family Service (~~DCFS~~)~~[CG16][DB17]
- Adult Protective Services (APS) for vulnerable individuals age~~s~~ 18 to 59
- Governor's Office of Elderly Affairs Elderly Protective Services (EPS) for vulnerable individuals age~~s~~ 59 and older; and
- LDH Health Standards Section (HSS) for people who reside in a public or private i~~I~~ntermediate c~~C~~are f~~F~~acility (ICF) or ICF/nursing facilities, persons with developmental disabilities (ICF/DD), ~~ICF/nNursing fFacilities, a~~and ~~Child Protective Services (CPS)~~DCFS or APS cases in which the alleged perpetrator is an employee of an agency licensed by HSS~~.~~

Community providers are prohibited from using restrictive interventions/restraints. Any instances of restraint that threaten members' health and welfare should be reported and referred to the appropriate protective service agency and the HSS directly and immediately.

The following are types of adverse incidents:

- Abuse (child/youth): A ~~- a~~ny one of the following acts that seriously endanger the physical, mental~~,~~ or emotional health and safety of the child; ~~-~~ ~~T~~the infliction, attempted infliction, or, because of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person~~.~~
  - The exploitation or overwork of a child by a parent or any other person~~.~~
  - The involvement of a child in any sexual act with a parent or any other person~~.~~
  - The aiding or toleration~~o~~g by the parent or~~f~~ ~~the~~ caretaker of the child's sexual involvement with any other person or of the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under ~~the~~ Louisiana law~~s of this state.~~ (Louisiana ~~a.~~ Children's ~~-~~Code A~~a~~rticle~~t.~~ 603(2))
- Abuse (adult): ~~–~~ ~~T~~the infliction of physical or mental injury, or actions ~~which~~ that may reasonably be expected to inflict physical injury, on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation~~,~~ or extortion of funds or other things of value~~.~~ (Louisiana~~a.~~ Revised ~~-~~Statute~~.~~s 15:1503.2)~~.~~
- Death: ~~—~~ ~~r~~Regardless of cause or the location where the death occurred~~.~~
  - Documentation must address dates of all events and correspondence; cause of death; if the member was receiving hospice or home health services; the who, what, when, where and why facts concerning the death; and relevant medical history and critical incidents associated with the death.
- ~~-~~Exploitation (adult): ~~–~~ ~~t~~The illegal or improper use or management of the funds, assets~~,~~ or property of an older adult ~~person who is aged~~ or an adult with a disability, or the use of power of attorney or guardianship of an older adult ~~person who is aged~~ or an adult with a disability, for one's own profit or advantage~~.~~ (Louisiana Revised Statutes~~a. R.S.~~ 15:1503.7)~~.~~

- Extortion (adult): ~~.~~ tThe acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority~~.~~ (Louisiana Revised Statutes~~a. R.S.~~ 15:503.8)~~.~~
- Neglect (child/youth): ~~.~~ tThe refusal or unreasonable failure of a parent of caretaker to supply the child with the necessary food, clothing, shelter, care, treatment~~,~~ or counseling for any illness, injury or condition of the child, as a result of which the child's physical, mental or emotional health and safety are substantially threatened or impaired
  - ~~.~~ This includes illegal prenatal ~~illegal~~ drug exposure caused by the parent, resulting in the nNewborn being affected by the drug exposure and withdrawal symptoms~~.~~ (Louisiana Children's Code Article ~~La. Ch. Code art.~~ 603(18)).
- Neglect (adult): ~~.~~ tThe failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical~~,~~ or any other care necessary for ~~his or her~~the adult's well-being~~.~~
  - ~~.~~ No adult who is ~~being~~ provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused~~.~~ (Louisiana Revised Statutes ~~La. R.S.~~ 15:1503.10).

Credentialing and recredentialing

Practitioners ~~included~~ within the scope of credentialing for Louisiana Medicaid include~~, but may not be limited to~~:

- Medical and osteopathic doctors
- Oral surgeons
- Chiropractors
- Podiatrists
- Dentists
- Optometrists
- Other licensed or certified practitioners, including ~~physician~~ provider extenders who act as a ~~primary care provider~~PCP or those who appear in the provider directory
- Pharmacists who practice within a medical office setting

Behavioral health providers, including those who are:

- Fully licensed mental health professionals, meaning ~~a~~ licensed mental health professionals (LMHPs) ~~is an individual~~who are licensed in the s~~S~~tate of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable laws and their professional license
  - ~~.~~ LMHPs include the following specialists~~ties~~ who are licensed to practice independently:
    - ~~o~~ Medical psychologists
    - ~~o~~ Licensed psychologists
    - ~~o~~ Licensed clinical social workers (LCSWs)
    - ~~o~~ Licensed professional counselors (LPCs~~))@kath~~
  - Licensed marriage and~~&~~ family therapists (LMFTs)
  - Licensed addiction counselors (LACs)
  - Advanced practice registered nurses (APRN) ~~that~~ who meet behavioral health~~BH~~ specialist qualifications
- As permitted by service and provider qualifications, certain provisionally licensed providers, including:
  - Provisionally licensed professional counselors (PLPCs)
  - Provisionally licensed marriage and~~&~~ family ~~-~~therapists (PLMFTs)
- As permitted by service and provider qualifications, certain providers with a master's level of education, including:
  - Licensed master social workers (LMSWs)
  - Certified social workers (CSWs)[CC18][DB19]
  -
- As permitted by service and provider qualifications, certain behavioral health intern providers, including:
  - Psychology interns from an internship program approved by the American Psychological Association (APA) ~~n APA approved internship program~~[CC20][DB21]
- As permitted by service and provider qualifications, certain individuals employed by a LDH licensed b~~B~~ehavioral h~~H~~ealth s~~S~~ervice p~~P~~rovider (BHSP) [CC22][DB23]~~that~~ who have a bachelor's level of education from an accredited university or college in at least one of the following fields:
  - Counseling
  - Social work
  - Psychology
  - Sociology

- Rehabilitation services
- Special education
- Early childhood education
- Secondary education
- Family and~~&~~ consumer sciences

- ○
  - Criminal justice
  - Human growth and& development
- As permitted by service and provider qualifications, certain individuals employed by a licensed BHSP ~~that~~ who have a bachelor's level of education from an accredited university or~~f~~ college with a minor in at least one of the following fields:
  - Counseling
  - Social work
  - Sociology
  - Psychology
- As permitted by service and provider qualifications, certain unlicensed individuals employed by a ~~LDH~~ licensed BHSP [CC24][DB25][CC26][DB27]~~that~~who:
  - ~~Are 21 years of age or older as of 01/01/2022~~Meet established age requirements~~; and~~
  - ~~Have a high school diploma or GED; and~~Have completed the required training as determined by the service(s) offered~~; and~~
  - ~~Have been continuously employed by a licensed and accredited agency providing PSR services prior to 01/01/2019~~Meet~~s~~ all other applicable requirements defined in the Louisiana~~ouisiana Department of Health's~~ Medicaid Behavioral Health Services Provider Manual~~.~~

Behavioral health providers [CC28][DB29]must include the following additional supporting documentation as part of credentialing and recredentialing, as applicable:

- Staff r~~R~~oster
- ~~Specialty Profile~~Profiling form(s)
- Attestation for services offered

Humana Healthy Horizons ~~in Louisiana~~ conducts credentialing and recredentialing activities utilizing the guidelines established by ~~the Louisiana Department of Health (~~LDH~~)~~, including but not limited to the Louisiana~~DH's~~ Medicaid Behavioral Health Services Provider Manual, the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Humana Healthy Horizons ~~in Louisiana~~ credentials and recredentials all licensed independent practitioners including ~~physicians~~providers, facilities and~~,~~ licensed and non-licensed personnel ~~with which~~ it contracts with and who fall within its scope of authority and action within 60 calendar days of receipt of a completed application. Through credentialing, Humana Healthy Horizons ~~in Louisiana~~ verifies the qualifications and performance of ~~physicians and other~~ healthcare ~~practitioners~~providers. A senior Humana Healthy Horizons ~~in Louisiana~~ clinical staff person is responsible for oversight of the credentialing and recredentialing program. Upon LDH's selection and implementation of a credentials verification organization (CVO),

Humana Healthy Horizons ~~in Louisiana~~ will accept the credentialing and recredentialing decisions of the CVO's credentials committee for our Louisiana Medicaid provider network.

All providers should complete the credentialing or recredentialing process prior to the provider's effective contract ~~effective~~ date, except where required by state regulations. Additionally, a provider will only appear in the provider directory once credentialing is complete.

~~How to j~~Join~~Joining~~ the Humana Healthy Horizons ~~in Louisiana P~~provider n~~N~~etwork

Providers interested in contracting with Humana Healthy Horizons ~~in Louisiana,~~ should send an email to:

- Medical providers~~:~~ ~~—~~LAMSProivderIntake@~~H~~humana.com
- Behavioral h~~H~~ealth providers~~:~~ ~~—~~LABHMedicaid@h~~H~~umana.com

Please include the following details in your email when requesting to join the network:

- ~~Physician~~Provider, p~~P~~ractice and/or f~~F~~acility name
- Service address with phone, fax and email information
- Mailing address, i~~f~~ different from the service location~~, please include the mailing address~~
- Taxpayer I~~i~~dentification N~~n~~umber (TIN)
- Practicing specialty[CC30][DB31][CC32][DB33]
- Louisiana Medicaid provider number, including the registered provider and specialty type codes[CC34][DB35] if applicable
- National Provider Identifier (NPI)
- Type of contract ~~type~~ you are requesting:
  - Individual
  - Group

- Facility

Once we receive your request, a pProvider cContracting rRepresentative will review the request and contact you. During the contracting process, you will be asked to submit a credentialing application and supporting documentation that areis relevant to your provider type. T. The most common credentialing documents requested include:

- Credentialing application
  - Individual practitioners will be asked for your Council for Affordable Quality Healthc Care (CAQH®) number. Please ensure your CAQH® application and supporting documents are current and that . Please ensure you've granted Humana Healthy Horizons in Louisiana

- access to your application.
- Facilities will be asked to complete Humana Healthy Horizons's Organizational Provider Assessment Form and include supporting documentation applicable to your provider type.

- Proof of current insurance coverage
  - Professional liability insurance coverage ; or coverage through
  - the Louisiana Patient Compensation Fund
- Disclosure of Ownership

Humana Healthy Horizons in Louisiana will acknowledge we've receivedreceipt of your application within five (5) calendar days. . If we identify your application is incomplete, including if any information or documentation is missing, invalid or expired information or documentation, we will notify you in writing within thirty (30) days calendar days. C. Complete credentialing applications are completely processed within sixty (60) calendar days.

You may submit a completed CAQH application or Louisiana Standardized Credentialing Application Form using one of the following email addresses:

- Behavioral Health providers: LABHMedicaid@hHumana.com
- Physical Health providers: LAMSProviderIntake@hHumana.com

CAQH application

Humana Healthy Horizons in Louisiana is a participatesing organization with the Council for Affordable Quality Healthcare (CAQH). You can confirm we have access to your credentialing application by completing the following steps:

1. Log Sign in toonto the CAQH website at CAQH websiteproview.caqh.org using your account information.
2. Select the **Authorization** tab.
3. Confirm Humana Healthy Horizons in Louisiana is listed as an authorized health plan; if not, please click select the "**Authorized**" box to add it.

Please include your CAQH provider ID number when submitting credentialing documents. It is essential that all documents are complete and current. If you choose not to complete a CAQH application, Humana Healthy Horizons will accept Louisiana's Standardized Credentialing Application. Please include copies of the following documents with your application:

- Current malpractice insurance face sheet
- A current Drug Enforcement Administration (DEA) certificate
- All buprenorphine prescribers must have an "X" DEA number
- Explanation of any lapse in work history of 6six months or greater
- Clinical Laboratory Improvement Amendments (CLIA) certificate, as applicable
- Copy of a collaborative practice agreement between an advanced practice registered nurse (APRN) apractitioner and supervising practitioner
- Educational Commission for Foreign Medical Graduates (ECFMG) certification, if foreign medical degree

Failure to submit a complete application may result in a delay in our ability to begin or complete or begin the credentialing process.

Practitioner credentialing and recredentialing

The following elements also are used to assess practitioners for credentialing and recredentialing:

- Signed and dated credentialing application, including supporting documents
- Active and unrestricted license in the practicing state, issued by the appropriate licensing board
- Previous five5-year work history
- Current Drug Enforcement Administration (DEA) certificate and/or state narcotics registration, as applicable
- Education, training and experience are current and appropriate to the scope of practice requested
- Successful completion of all training programs pertinent to one's practice
  - For physiciansproviders, successful completion of residency training pertinent to the requested practice type
  - For dentists and other providers where special training is required or expected for requested services, successful completion of a training program
- Board certification, as applicable
- Current malpractice insurance coverage of at least the minimum amount in accordance with Louisiana laws
- Providers, including owners and managers, must be in good standing with federal and state agencies, including but not limited to:

- Medicaid agencies
- The Medicare program
- Health and& Human Services Office of Inspector General (HHS-OIG)
- General Services Administration (GSA, formerly Excluded Parties List System/EPLS)

- Active hospital privileges, as applicable
- ~~National Provider Identifier (~~NPI~~)~~, as verifiable via the National Plan and Provider Enumerator System (NPPES)
- Quality of care and practice history as judged by:
  - Medical malpractice history
  - Hospital medical staff performance
  - Licensure or specialty board actions or other medical or civil disciplinary actions
  - Absence of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
  - Other quality-of-care measurements/activity
- Disclosure of medical practice and/or ~~physician~~ provider group ownership

Organizational credentialing and recredentialing—physical health

Organizational providers providing physical health services assessed for credential award include, but are not limited to:

- Hospitals
- Psychiatric h~~H~~ospitals
- Home health agencies
- Skilled -nursing facilities
- Free-standing ambulatory surgery centers
- Hospice providers
- Dialysis centers
- Physical and~~,~~ occupational therapy and speech-language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals including outpatient locations
- Diabetes education
- Portable X-ray suppliers
- Rural H~~h~~ealth C~~c~~linics (RHCs) and F~~f~~ederally Q~~q~~ualified H~~h~~ealth C~~c~~enters (FQHCs)
- School-based health clinics
- Local parish health clinics
- Indian healthcare providers

The following elements are assessed for organizational providers providing physical health services:

- Confirmation of the organization's good standing with:
  - Medicaid agencies
  - The Medicare program
  - ~~Health & Human Services Office of Inspector General (~~HHS-OIG~~)~~
  - ~~General Services Administration (~~GSA, formerly EPLS~~)~~
- Healthcare providers ~~must be~~ screened by and enrolled with LDH to be considered for participation
- Active and valid Louisiana Medicaid ID ~~number~~
- Organization ~~has been~~ reviewed and approved by CMS or an accrediting body
- Copy of facility's state license, as applicable
- ~~National Plan and Provider Enumerator System (~~NPPES~~)~~
- Current CLIA certificates ~~are current~~, as applicable
- Completion of a signed and dated application
- Completed disclosure of ownership form

Organizational credentialing and recredentialing—behavioral health[CC36][DB37]

Organizational providers providing behavioral health services assessed for credential award include, but are not limited to:

- Therapeutic group homes (TGHs)
- Therapeutic foster care
-
- ~~Psychiatric residential treatment facilities (~~PRTFs~~)~~
- ~~Federally Qualified Health Centers (~~FQHCs~~)~~
- ~~Rural Health Clinics (~~RHCs~~)~~

- Outpatient tTherapy facilities by lLicensed pPractitioners

- LMPHs groups[CC38][DB39][CC40]
- Mental hHealth rRehabilitation agencies(MHR)
- Mental health clinics (MHC) – reserved for local government agencies (LGE)
-
- ~~Home- and & cCommunity-b Based servicesSupports (HCBS)~~[CC41][DB42]
- Community mMental hHealth centers ~~Clinics~~ (CMHCs)
- School-~~b~~ Based hHealth ~~Clinics~~centers
- Substance use residential treatment facilities
- Substance use and alcohol abuse centers (outpatient)
- Opioid treatment programs (OTP)
- Free-standing psychiatric hospitals
- Distinct part psychiatric units
- Center based respite
- Crisis receiving centers
- Personal care services (PCS) – behavioral health
-
  - ~~Behavioral health service provider agencies offering coordinated system of care services, including wraparound services:~~
    - ~~Parent Support and Training~~
    - ~~Youth Support and Training~~
- Behavioral health services provider agencies offering evidence-based practice services:[CC43]
  - Assertive ~~community~~ Community ~~treatment~~Treatment (ACT)[CC44][DB45]
  - Functional F~~f~~amily T~~t~~herapy (FFT)
  - Functional Family T~~t~~herapy ~~–~~ – C~~c~~hild W~~w~~elfare (FFT-CW)
  - Home~~b~~B~~u~~ilders®
  - ~~Home and Community Based Service~~HCBS ~~p~~Providers/ ~~p~~Personal ~~c~~Care ~~a~~Attendant ~~a~~Agencies[CC46][DB47]
  - Multi-systemic therapy (MST)

~~The following e~~Elements ~~are~~ assessed for organizational providers providing behavioral health services:

- Confirmation of the organization's good standing with:
  - Medicaid agencies
  - The Medicare program
  - ~~Health & Human Services Office of Inspector General (~~HHS-OIG~~)~~
  - ~~General Services Administration (~~GSA, formerly EPLS~~)~~
- Healthcare providers ~~must be~~ screened by and enrolled with LDH to be considered for participation as applicable
- Active and valid Louisiana Medicaid ID as applicable [CC48][DB49]~~number~~[CC50][DB51]
- ~~As applicable,~~ Organization ~~has been~~ reviewed and approved by an accrediting body approved by LDH, as applicable~~.~~
- LDH approved accrediting bodies are:
  - The Joint Commission (TJC)
  - The Commission on Accreditation of Rehabilitation Facilities (CARF)
  - The Council on Accreditation (COA)
- Copy of facility's state license, as applicable
- ~~National Provider Identifier (~~NPI~~)~~, as verifiable via the ~~National Plan and Provider Enumerator System (~~NPPES~~)~~
- Current CLIA certificates ~~are current~~, as applicable
- Completion of a signed and dated application
- Completed disclosure of ownership form

Organizational behavioral health providers must include the following additional supporting documentation as part of credentialing and recredentialing:

- Staff rRoster
- ~~Specialty Profile~~Profiling form(s)
- Attestation for services offered

Provider recredentialing

Network providers, including practitioners and organizational providers, are recredentialed at least once every ~~three~~ 3 years. In accordance with Louisiana Revised Statutes~~La. R.S.~~ 46:460.72(B), providers are sent at least ~~three~~ 3

written notices and given at least ~~six~~ 6 months' notice of their recredentialing due date. A. ~~A~~s part of the recredentialing process, Humana Healthy Horizons also examines performance information regarding complaints and~~,~~ safety and quality issues collected through the quality improvement program. Additionally, information regarding adverse actions is collected from the National Practitioner Data Bank (NPDB), Medicare and Medicaid s~~S~~anctions, the CMS Preclusion L~~l~~ist, the HHS~~-~~/OIG and GSA (formerly EPLS), and limitations on licensure.

Exemption from MCO c~~C~~redentialing and r~~R~~ecredentialing

In accordance with Louisiana Revised Statutes ~~La. R.S.~~ 46:460.61, Humana Healthy Horizons will consider providers who maintain hospital privileges or are members of the medical staff of a hospital, ~~federally qualified health center (~~FQHC~~),~~ or ~~rural health clinic (~~RHC~~)~~, ~~Humana will consider these providers~~ as having satisfied, and be otherwise exempt from having to satisfy, any credentialing requirements for the Humana Healthy Horizons ~~in Louisiana~~ provider network. ~~.~~ Humana Healthy Horizons will track providers who were credentialed by a hospital, FQHC or RHC, including the expiration and/or termination of privileges and/or employment. U~~.~~ ~~U~~pon notice of expiration and/or termination, such that the provider no longer maintains any hospital privilege and is no longer a member of the medical staff of any hospital, FQHC~~,~~ or RHC, Humana Healthy Horizons will follow the standard process for credentialing a new provider.

Provider rights

- ~~Practitioners~~ Providers have the right to review, upon request, information submitted to the Humana Healthy Horizons ~~in Louisiana~~ c~~C~~redentialing department in support of ~~his or her~~the pr~~actitioner~~ovider's credentialing application. Humana Healthy Horizons ~~in Louisiana~~ keeps all submitted information locked and confidential. Access to electronic credentialing information is password protected and limited to staff who require access for business purposes.
- ~~Practitioners~~ Providers have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the credentialing department prior to presentation to the credentialing committee. If information obtained during the credentialing or recredentialing process varies substantially from the application, the ~~practitioner~~ provider is notified and given the opportunity to correct information prior to presentation to the credentialing committee.
- ~~Practitioners~~ Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the credentialing department.

Provider responsibilities

Providers~~,~~ are required to meet all state and federal participation requirements, including but not limited to, background screening compliance. P~~.~~ Providers must perform federal~~-~~ and state~~-~~mandated exclusion background checks annually on all providers, including owners and managers. Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana Healthy Horizons ~~in Louisiana~~ will initiate immediate action if the participation criteria are no longer met.

Network providers are required to inform Humana Healthy Horizons of changes in status, including but not limited to:

- Being named in a medical malpractice suit
- Involuntary hospital privilege changes
- Changes in licensure or board certification
- Any event reportable to the ~~National Practitioner Data Bank (~~NPDB~~)~~
- Federal, state~~,~~ or local sanctions or complaints

Delegation of credentialing/recredentialing[CC52][DB53][CC54][DB55]

Humana Healthy Horizons ~~in Louisiana~~ will only enter into agreements to delegate credentialing and recredentialing if the entity seeking delegation is accredited by NCQA for these functions or ~~utilizes an NCQA-accredited credentials verification organization (CVO)~~ adheres to NCQA standards and successfully passes a pre~~-~~delegation audit demonstrating compliance with NCQA
federal and state requirements. A pre-delegation audit must be completed prior to entering into a delegated agreement. All pre~~-~~assessment evaluations will be performed using the most current NCQA and regulatory requirements.

The following (at a minimum) ~~will be~~is included ~~(at a minimum)~~ in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing file review

Delegates must be in good standing with Medicaid agencies and CMS. Monthly reporting will be required from the delegated entity, which will be defined in an agreement between both parties.

~~The Contractor~~Humana Healthy Horizons ~~shall~~[CC56][DB57]will not delegate credentialing of specialized behavioral health providers except as allowed by La. R.S. 46:460.61 or approved by LDH in writing in advance.

Reconsideration of credentialing and recredentialing decisions

Humana Healthy Horizons' ~~in Louisiana's~~ credentials committee may deny a provider's request for participation based on credentialing criteria.
The credentials committee must notify a provider of a denial that is based on credentialing criteria and provide the opportunity to request reconsideration of the decision within 30 days of the notification. Reconsideration opportunities are available to a provider if ~~he or she is~~ they are affected by an adverse determination.

To submit a reconsideration request, mail your written request to the senior medical director. It must include any additional supporting documentation.

Mail it to:

Humana
<Attn: ~~Jennifer~~
~~Moncrief~~Shoba Srikantan,
M.D.> ~~Regional~~ Humana
Medical Director 101 E. Main
St.
Louisville, KY 4~~Y 4~~0202

Upon reconsideration, the credentials committee may affirm, modify or reverse its initial decision. Humana Healthy Horizons ~~in Louisiana~~ will notify the applicant, in writing, within 60 days of the credentials committee's reconsideration d~~n~~

decision. Reconsideration denials are final unless the decision is based on quality criteria, in which and the provider has the right to request a fair hearing. Practitioners denied renewal of their credentials may reapply for network participation once they meet the minimum of the health plan's credentialing criteria.

Newly applying providers have no appeal rights, but additional documents may be submitted to the above address for reconsideration of their application by the credentialing committee.

Excluded providers

Except for certain emergency services, Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid or Children's Health Insurance Program. If FFP money is paid for services provided by an excluded provider, these payments may be recouped.

Provider disputes

Provider disputes that are contractual or nonclinical should be sent to:

Humana
Attn: Provider Relations
101 S. Fifth St.
Louisville, KY 40202

Adverse actions

Humana Healthy Horizons in Louisiana complies with the federal Health Care Quality Improvement Act of 1986 and has an active peer review committee. Humana Healthy Horizons in Louisiana reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a network provider, who, in the opinion of the Humana senior medical director or peer review committee, exhibits competence or professional conduct that adversely affects, or could adversely affect, a patient's health or welfare. is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our members. Participating providers who are subject to an adverse action that limits, reduces, restricts, suspends, terminates, denies, or fails to renew a provider's affects their status for more than 30 days are offered an opportunity to require a hearing before a separate hearing panel or officer. Such adverse actions are reported to the National Practitioner Data BankNPDB.for a fair hearing that entails an additional physician panel review of the action.

Delegated services, policies and procedures

Scope

The guidelines and responsibilities outlined in this appendix are applicable to all contracted Humana Healthy Horizons in Louisiana delegated entities (delegate). The policies in Humana Healthy Horizons in Louisiana's Provider Manual for Physicians, Hospitals and Other Healthcare Providers (manual) also apply to delegated entities.

The information provided is designed primarily for the delegate's administrative staff responsible for the implementation or administration of certain functions that Humana Healthy Horizons has delegated to an entity.

Overview

Humana Healthy Horizons in Louisiana may enter into a written agreement with another legal entity to delegate the authority to perform certain functions on its behalf, such as:

- Credentialing of physicians,healthcare providers and facilities and other healthcare providers
- Provision of clinical health services, such as Uutilization Mmanagement and population health management
- Claims adjudication and payment
- Inquiries in the medical and managed behavioral healthcare organization (MBHO) setting

Contact the local Humana Healthy Horizons in Louisiana market office provider representative for detailed information on delegation or call Provider Relations at

1-**800-448-3810** (TTY: 711).

Delegated providers must comply with the responsibilities outlined in the "Delegated sServices, pPolicies and pProcedures" section of this manual. Thise document is available from the local Humana Healthy Horizons market office, or by calling 1-**800-448-3810** (TTY: 711).

Oversight

Although a health plan can delegate the authority to perform a function, it cannot delegate the responsibility or accountability for ~~making sure~~ ensuring ~~that~~ the function is performed in an appropriate and compliant manner. Since Humana Healthy Horizons remains responsible for the performance and compliance of any function that is delegated, Humana Healthy Horizons ~~in Louisiana~~ provides oversight of the delegate.

Oversight is the formal process through which Humana Healthy Horizons ~~in Louisiana~~ performs auditing and monitoring of the delegate's:

- Ability to perform the delegated function(s) on an ongoing basis
- Compliance with accreditation organization standards, state and federal rules, laws and regulations, Humana Healthy Horizons ~~in Louisiana~~ policies and procedures, as well as the delegate's~~ir~~ underlying contractual requirements pertaining to the provision of healthcare services ~~and~~
- Financial soundness (if delegated for claims adjudication and payment)~~.~~

The delegation process begins with Humana Healthy Horizons ~~in Louisiana~~ performing a pre-delegation audit prior to any function being delegated to a prospective entity. After approval and an executed delegation agreement, Humana Healthy Horizons ~~in Louisiana~~ will perform an annual audit on an ongoing basis until the delegation agreement is terminated. At a minimum, these audits will include a review of the ~~applicable documents~~following, as applicable: ~~listed below:~~

- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreement(s)
- Audit(s) of sub-delegate's program including policies, procedures and program documents
- Letters of accreditation
- Financial solvency (claims delegation only)
- File audit
- Federal/state exclusion screenings
- Offshore contracting

Humana Healthy Horizons ~~in Louisiana will~~ continues to monitor all delegated entities through the collection of periodic reporting outlined within the delegation agreement. H~~. H~~umana Healthy Horizons ~~in Louisiana will~~ provides the templates and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons ~~in Louisiana~~ standards. Any changes will be communicated to the delegate at such time.

Corrective action plans

Failure of the delegate to adequately perform any of the delegated functions in accordance with Humana Healthy Horizons ~~in Louisiana~~ requirements, federal and state laws, rules and regulations, or accreditation organization standards may result in a written corrective action plan (CAP). The delegate ~~will~~must provide a written response describing how the delegate~~y~~ will meet the requirements found to be noncompliant, including the expected remediation date of compliance.

Humana Healthy Horizons ~~in Louisiana will~~ cooperates with the delegate or its subcontractors to correct any failure. Any failure by the delegate to comply with the delegate's ~~its~~ contractual requirements or this manual, or any request by Humana Healthy Horizons ~~in Louisiana~~ for the development of a CAP, may result, at Humana Healthy Horizon's discretion, in the immediate suspension or revocation of all or any portion of the functions and activities delegated. This includes withholding a portion of the reimbursement or payment under the contract agreement.

Humana, legal, regulatory and accreditation requirements

The delegate ~~will~~must comply with the following requirements:

- Submit any material change in the performance of delegated functions to Humana Healthy Horizons for review and approval, prior to the effective date of the proposed changes~~.~~
- ~~If required by state and/or federal law, rule or regulation, o~~Obtain and maintain, in good standing, a third-party administrator license/certificate and or a utilization review license~~/ or~~ certification if required by state and/or federal law, rule or regulation~~.~~
- Ensure that personnel who carry out the delegated services have appropriate training, licensure and/or certification~~.~~
- Adhere to Humana Healthy Horizons'~~ in Louisiana's~~ record retention policy for all delegated function documents, which is 10 years (the same as the CMS requirement)~~.~~

Sub-delegation

The delegate must have Humana Healthy Horizons'~~ in Louisiana's~~ prior written approval for any sub-delegation by the delegate of any functions and/or activities and notify Humana Healthy Horizons ~~in Louisiana~~ of any change~~d~~ to functions being delegated.~~or additional offshore locations or functions.~~ The d~~D~~elegate must provide Humana Healthy Horizons ~~in Louisiana~~ with documentation of the pre-delegation audit the~~at~~ delegate performed of the subcontractor's compliance with the functions and/or activities to be delegated.

~~In addition, Humana Healthy Horizons in Louisiana must notify CMS within 30 days of the contract signature date of any location outside of the U.S. nited States or a U.S. territory that receives, processes, transfers, stores or accesses Medicare beneficiary protected health information in oral, written or electronic form.~~

Note~~OTE~~: Certain states may prohibit Medicaid protected health information from leaving the U.S.~~nited States~~ or a U.S. territory.

If Humana Healthy Horizons ~~in Louisiana~~ approves the sub-delegation, the delegate will provide Humana Healthy Horizons ~~in Louisiana~~ documentation of a written sub-delegation agreement that:

- Is mutually agreed upon~~.~~
- Describes the activities and responsibilities of the delegate and the sub-delegate~~.~~
- Requires at least semiannual reporting of the sub-delegate to the delegate~~.~~
- Describes the process by which the delegate evaluates the sub-delegate's performance~~.~~
- Describes the remedies available to the delegate if the sub-delegate does not fulfill its obligations, including revocation of the delegation agreement~~.~~
- Allows Humana Healthy Horizons ~~in Louisiana~~ access to all records and documentation pertaining to monitoring and oversight of the delegated activities~~.~~
- Requires the delegated functions to be performed in accordance with Humana Healthy Horizons ~~in Louisiana~~ and delegate's requirements, state and federal rules, laws and regulations and accreditation organization standards and subject to the terms of the written agreement between Humana Healthy Horizons and the delegate~~.~~
- Retains Humana Healthy Horizons'~~ in Louisiana's~~ right to perform evaluation and oversight of the subcontractor~~.~~

The delegate is responsible for providing adequate oversight of the subcontractor and any other downstream entities. T~~. T~~he delegate must provide Humana Healthy Horizons with documentation of such oversight prior to delegation and annually thereafter. Humana Healthy Horizons ~~in Louisiana~~ retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by Humana Healthy Horizons. Furthermore, Humana Healthy Horizons ~~in Louisiana~~ retains the right to modify, rescind or terminate, at any time, any one or all delegated activities, regardless of any sub-delegation that may previously have been approved.

~~thereafter. Humana Healthy Horizons in Louisiana retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by Humana. Furthermore, Humana Healthy Horizons in Louisiana retains the right to modify, rescind or terminate, at any time, any one or all delegated activities, regardless of any sub-delegation that may previously have been approved.~~

Delegate agrees to monitor the subcontractor for federal and state government program exclusions on a monthly basis for ~~Medicare and~~ Medicaid providers and will maintain such records for monitoring activities. If the delegate finds that a provider, subcontractor or employee is excluded from any federal and/or state government program, the delegate~~y~~ will be removed immediately from providing direct or indirect services for Humana Healthy Horizons members~~ immediately~~.

~~Appeals and g~~Grievances and appeals

~~Humana Healthy Horizons in Louisiana member appeals/grievances and expedited appeals are not delegated, including any appeal made by a physician/provider on behalf of the member.~~ Humana Healthy Horizons ~~in Louisiana~~ maintains all member rights and responsibility functions except in certain special circumstances. Therefore, the delegate ~~will~~must:

- Forward all standard member appeals/grievances to Humana Healthy Horizons within ~~one~~ 1 business day
  Phone: 1-**800-448-3810 (TTY: 711)**
  - Fax: 1-**800-949-2961**~~.~~
- Forward all expedited appeals immediately upon notification/receipt
  - Phone: 1-**800-448-3810 (TTY: 711)**

  Fax: 1-**800-949-2961**~~.~~
- ~~When faxing, delegate will~~ Pprovide the following information when forwarding member appeals or grievances: date and time of receipt, member information, summary of the grievance or appeal~~ or grievance~~, all denial information, if applicable, and summary of any actions taken, if applicable~~.~~
- ~~Promptly e~~Effectuate promptly the appeal decision as rendered by Humana Healthy Horizons ~~in Louisiana~~ and support any requests received from Humana Healthy Horizons in an expedited manner~~.~~
- Handle ~~physician,~~ provider, hospital and other healthcare professional and/or participating provider claim payment and denial complaints or claim contestations and provider appeals regarding termination of the agreement~~.~~

- Refer to your delegation agreement for how to handle all non-participating provider appeals for claim~~s~~ payment and denials.

Utilization Management dDelegation

Delegation of Uutilization M management (UM) (UM) is the process by which the delegated entity evaluates the necessity, appropriateness and efficiency of healthcare services to be provided to members. Generally, a review coordinator gathers information about the proposed hospitalization, service or procedure from the patient and/or provider, and then determines whether it meets established guidelines and criteria. Reviews can occur prospectively, concurrently (including urgent/emergent) and/or retrospectively.

Utilization Management rRequirements:

All delegates performing Utilization ManagementUM activities must comply with and meet the rules and requirements for processing Utilization Management requests established or implemented by the state. I. In addition, they must conduct all Utilization UManagement activities in accordance with NCQA standards, the member's plan, and Humana Healthy Horizons' in Louisiana's policies and procedures. H. Humana Healthy Horizons in Louisiana retains the right and final authority to review decisions for its members regardless of any delegation of such functions or activities to delegate. R. Refer to your delegation agreement for specifics.

The dDelegate is to conduct the following functions regarding initial and expedited/urgent determinations:

- Maintain policies and procedures that address all aspects of the Utilization Management process, including a member's right to a second opinion
  - Policies and procedures must be formally reviewed, revised, dated and signed annually. Effective dates are present on policies or on a policy master list.
- Perform preadmission review and authorization, including medical necessity determinations based on approved

criteria, specific benefits and member eligibility.

- In full-risk arrangements, Humana Healthy Horizons in Louisiana performs this function when review decisions by the delegate are not timely, are contrary to medical necessity criteria and/or when Humana Healthy Horizons in Louisiana must resolve a disagreement between among the delegate, providers and the member. In some local health plans, Humana Healthy Horizons may assume total responsibility for this function. R. Refer to your delegation agreement for specifics.
- For concurrent review activities relevant to inpatient and skilled nursing facility (SNF) stays, the delegate should:
  - Provide on-site or telephone review for continued stay assessment using approved criteria
  - Identify potential quality-of-care concerns, including hospital reportable incidents, including, but not limited to, sentinel events and never events, and notification to the local health plan for review within 24 hours of identification or per contract. Humana Healthy Horizons in Louisiana does not delegate quality-of-care determinations.
  - Provide continued stay determinations
  - Perform discharge planning and retrospective review activities
- Perform, manage and monitor the referral process for outpatient/ambulatory care
- .Determine the appropriateness of each referral to specialists, therapists, etc., as it relates to medical necessity.
  - .The d-Delegate is also is responsible for conducting retrospective reviews for outpatient/ambulatory care.
- Perform Utilization Management activities for out-of-service areas and out-of-network providers as dictated by the contract.
- Notify the member, facility and provider of the decision on decision on initial determinations using Humana Healthy Horizons in Louisiana/-CMS-approved letter templates.
- Utilize Humana Health Horizons' prior authorization list (PAL)
  - .If the delegate is delegated for both Utilization Management and claim payment, the delegate may develop their own PAL. However, the delegate's PAL may not be more stringent than Humana Healthy Horizons' PAL. If the delegate is not delegated to process claims on Humana Healthy Horizons' behalf, the delegate must utilize Humana Health Horizons' PAL.
- If the delegate is delegated for both Uutilization Mmanagement and claims payment, the delegate may utilize Humana Healthy Horizons' in Louisiana's prior authorization list (PAL) or develop their own PALone. H. However, the delegate's PAL may not be more stringent than Humana Healthy Horizons's PAL. I. If the delegate is not delegated to process claims on Humana Healthy Horizons's behalf, the delegate must utilize Humana Healthy Horizons' in Louisiana's PAL.
- For all determinations, mMaintain a log and submit it as required by regulatory and accreditation organization requirements
  - .Humana Healthy Horizons in Louisiana retains the right to make the final decision regardless of contract type.
- Maintain documentation of pertinent clinical information gathered to support the decision.
- Understand that all Utilization Management files and supporting documentation are Humana Healthy Horizons' in Louisiana's property
  - .Should the contract between the delegate and Humana Healthy Horizons be dissolved for any reason, the delegate is expected to make available to Humana Healthy Horizons in Louisiana either the original or quality copies of all Utilization Management files for Humana Healthy Horizons in Louisiana members.
- Provide applicable Utilization Management reporting requirements outlined within the contract and related addenda or attachments
  - .Humana Healthy Horizons in Louisiana will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons standards. Any changes will be communicated to the delegate at such time.

For concurrent review activities relevant to inpatient and skilled nursing facility stays, the delegate should:

- Provide on-site or telephone review for continued stay assessment using approved criteria
- Identify potential quality-of-care concerns, including sentinel events and never events, and notify the local health plan for review within 24 hours of identification or per contract
  - .Humana Healthy Horizons does not delegate quality-of-care determinations.
- Provide continued stay determinations
- Perform discharge planning and retrospective review activities

-In full-risk arrangements, Humana Healthy Horizons will perform utilization management when review decisions by the delegate are not timely, are contrary to medical necessity criteria and/or when Humana Healthy Horizons must resolve a disagreement among the delegate, providers and the member. In some local health plans, Humana Healthy Horizons may assume total responsibility for this function. Refer to your delegation agreement for specifics.

Care management delegation

Delegation of care management must include:

Complex cCase mMmanagement (CCM): Complex case management CM is coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Chronic condition management (CCM): Chronic condition management is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, established medical conditions.

The dDelegate should provide applicable care management reports as outlined within the contract and related addenda or attachments. Humana Healthy Horizons in Louisiana will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons in Louisiana standards. Any changes will be communicated to the delegate at such time.

Claims delegation

Claims delegation is a formal process by which a health plan gives a participating provider (delegate) the authority to process claims on its behalf. Humana Healthy Horizons' in Louisiana's criterion for defining claims delegation is when the risk provider pays fee-for--service claims. Capitation agreements in which the contractor pays downstream contractors via a capitation distribution formula do not fall under the definition of claims delegation.

Humana Healthy Horizons in Louisiana retains the right and final authority to pay any claims for its members regardless of any delegation of such functions or activities to delegate. Amounts authorized for payment by Humana Healthy Horizons in Louisiana of such claims may be charged against the delegate's funding. Refer to the contract for funding arrangement details.

Claims performance requirements: All delegates performing claim~~s~~ processing must comply with and meet the rules and requirements for the processing of Medicaid claims established or implemented by the state.

In addition, they must conduct claims adjudication and processing in accordance with the member's plan and Humana Healthy Horizons~~' in Louisiana's~~ policies and procedures. The d~~D~~elegate will need to meet, at a minimum, the following claims adjudication and processing requirements:

- The d~~D~~elegate must accurately process at least 95% of all delegated claims according to Humana Healthy Horizons ~~in Louisiana~~ requirements and in accordance with your contract, state and federal laws, rules and regulations and/or any regulatory or accrediting entity to whom Humana Healthy Horizons ~~in Louisiana~~ is subject.
- The d~~D~~elegate must meet applicable state and/or federal requirements to which Humana Healthy Horizons ~~in Louisiana~~ is subject for denial and appeals language in all communications made to members and use Humana Healthy Horizons~~' in Louisiana's~~ member letter template.
- Since Humana Healthy Horizons ~~in Louisiana~~ does not delegate nonparticipating provider reconsideration requests, the delegate should forward all requests to Humana Healthy Horizons ~~in Louisiana~~ upon receipt.
- The delegate shall provide a financial guarantee, acceptable to Humana Healthy Horizons ~~in Louisiana~~, prior to implementation of any delegation of claim~~s~~ processing, such as a letter of credit, to ensure its continued financial solvency and ability to adjudicate and process claims. T~~. T~~he delegate shall submit appropriate financial information upon request as proof of its continued financial solvency.
- The delegate shall supply staff and systems required to provide claims and encounter data to Humana Healthy Horizons ~~in Louisiana~~ as required by state and federal rules, regulations and Humana Healthy Horizons ~~in Louisiana~~. Refer to the Process Integration Agreement for details.
- The delegate should use and maintain a claim~~s~~ processing system that meets current legal, professional and regulatory requirements.
- The delegate should print its name and logo on applicable written communications, including letters or other documents related to adjudication or adjustment of member benefits and medical claims.

Credentialing delegation

The delegate is to comply with Humana Healthy Horizons~~' in Louisiana's~~ credentialing and recredentialing requirements, all applicable state and federal laws, rules and regulations and NCQA s~~S~~tandards and g~~G~~uidelines for the a~~A~~ccreditation of Medicaid MCO~~anaged Care Organizations~~ requirements pertaining to credentialing and/or re~~-~~credentialing. This includes maintaining a credentialing committee, a credentialing and recredentialing program, and all related policies, procedures and processes in compliance with these requirements.

~~compliance with these requirements.~~

Humana Healthy Horizons ~~in Louisiana~~ is responsible for the collection and evaluation of ongoing monitoring of sanctions and complaints. I~~. I~~n addition, Humana Healthy Horizons ~~in Louisiana~~ retains the right to approve, deny, terminate or suspend new or renewing practitioners and organizational providers from participation in any of the delegator's networks.

Reporting requirements: Complete listings of all participating providers credentialed and/or recredentialed are due on a semiannual basis or more frequently if required by state law. In addition, the delegate should submit reports to Humana Healthy Horizons ~~in Louisiana~~ of all credentialing approvals and denials within 30 days of the final credentialing decision date. The d~~D~~elegate should, at a minimum, include the elements indicated below in credentialing reports to Humana Healthy Horizons ~~in Louisiana~~:

- Practitioner
- Degree
- Practicing specialty
- NPI ~~number~~
- Initial credentialing date
- Last recredentialing date
- Specialist/hospitalist indicator
- State of practice
- License
- Medicare/Medicaid number
- Active hospital privileges (if applicable)

Chapter 4~~HAPTER IV~~: Covered services~~OVERED SERVICES~~[CC58][DB59][CC60][DB61]

General services

Humana Healthy Horizons ~~in Louisiana~~ is required to arrange, through its contracted providers, the following medically necessary services for each member.~~,~~ *"* "In lieu of"" services ~~(ILOS)~~ are alternative services or settings covered by Humana Healthy Horizons ~~in LA~~ as a substitute or alternative to services or settings covered under the Louisiana Medicaid ~~s~~State p~~P~~lan. In accordance with 42 C~~.~~F~~.~~R~~.~~ § 438.3(e)(2), "in lieu of"~~ILOS~~ are medically appropriate and cost-effective substitute services that are offered voluntarily by the MCO~~,~~. A listing of all covered behavioral health services can be found in the Behavioral health services section of this manual.

Service/b~~B~~enefit	Covered s~~S~~ervice/b~~B~~enefit	Limits /s~~S~~pecial i~~I~~nstructions
23-h-~~H~~our o~~O~~bservation for b~~B~~ehavioral h~~H~~ealth	Inpatient hospital-based intervention designed to allow for the opportunity to hold and assess a member without ~~admitting the~~admission~~m.~~	Offered by Humana Healthy Horizons ~~in Louisiana~~ as an in lieu of service* *. No prior authorization ~~is~~ required.~~.~~ May be subject to clinical claims review.~~.~~
Allergy t~~T~~esting and a~~A~~llergen i~~I~~mmunotherapy	Testing and treatment for allergies to things like food, animals, pollen~~s~~ and dust mites	Prior authorization ~~is~~ not required, but coverage limitations ~~do~~ apply
Ambulatory s~~S~~urgical s~~S~~ervices	Outpatient surgical center for procedures that do not require an inpatient hospital stay	Prior authorization may be required~~.~~. Refer to the ~~the~~ Humana Healthy Horizons ~~in Louisiana prior authorization list~~PAL for ~~that has~~ services ~~that~~ requiring~~e~~ prior authorization.
Anesthesia	Insensitivity to pain, especially as artificially induced by the administration of gases or the injection of drugs before surgical operations	
Applied b~~B~~ehavior a~~A~~nalysis t~~T~~herapy	Focuses on improving specific behaviors, such as social skills, communication, reading~~,~~ and academics as well as adaptive learning skills, such as ~~a~~ fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality~~,~~ and job competence	Covered for members ~~from~~ age 0~~–~~20; ~~P~~prior authorization ~~is~~ required
Audiology s~~S~~ervices	Services related to hearing and hearing structures of the ear	
Bariatric s~~S~~urgery	Open or laparoscopic procedures that revise the gastrointestinal anatomy to restrict the size of the stomach~~,~~ ~~to~~ reduce absorption of nutrients, or both for weight loss; c~~C~~overed when determined to be medically necessary	Prior authorization ~~is~~ required.
Breast s~~S~~urgery	Mastectomy, breast reconstruction, reduction mammoplasty and removal of breast implants when ~~it is~~ determined to be medically necessary	Prior authorization ~~is~~ required.

Chimeric antigen receptor (CAR) T-cCell Ttherapy	Inpatient and, if deemed appropriate, outpatient coverage of CAR T-cell therapy when such therapy is approved by the United States Food and Drug AdministrationFDA.	
Chiropractic sServices	Medically necessary cChiropractic services when the service is provided as a result of a referral from an EPSDT medical screening provider or Primary Care Provider (PCP)	Covered for members from age 0-20 under EPSDT. Covered for members age 21 and above+ as an lin lieu of service. Prior authorization required after 18 visits.
Cochlear iImplant	Includes: • Preoperative evaluation • Implants, equipment, repairs, and replacements • Implantation procedure, postoperative rehabilitative costs, and subsequent therapy • Post-operative programming	Covered for members from age 0-20; Pprior authorization required for all aspects of cochlear care.
Coordinated sSystem of cCare (CSoC)	A component of the system of care for youth who have significant behavioral health challenges and who are in or at imminent risk of out-of-home placement. Includes: Psychiatric Residential Treatment Facility (PRTF) Therapeutic Group Home (TGH) Substance uUse dDisorders (SUD) rResidential services	Covered for members from age 0-20[CC62][DB63]
Dental sServices - - - eEmergency	Services to restore a natural tooth, as best as possible, due to accidental injury	Covered for all members
Diabetes sSelf-mManagement tTraining (DSMT)	Training to teach members how to cope with and manage diabetes Includes: • Instructions for blood glucose self-monitoring • Education regarding diet and exercise • Individualized insulin treatment plan (for insulin-dependent members) • Encouragement and support for use of self-management skills • Parents or legal guardians can participate in DSMT rendered to their child.	A maximum of 10 hours of initial training (one1 hour of individual and nine9 hours of group sessions) are are allowed during the first 12-month period beginning with the initial training date. A maximum of twe2 hours of individual sessions are are allowed for each subsequent year.

Doula sServices	A doula is a trained professional who provides continuous physical, emotional, and informational support to a mother before, during and after childbirth to help her achieve the healthiest, most satisfying experience possible. Covered doula services include: • Prenatal doula advocacy visits to include up to five (5) prenatal visits. • Doula attendance at a birth, a one (1) time visit. • Postnatal doula advocacy visits to include up to three (3) postnatal visits.	Offered by Humana Healthy Horizons in Louisiana as an in lieu of service; . Nno prior authorization is required. May be subject to a clinical claims review.

Service/bBenefit	Covered sService/bBenefit	Limits/special instructionsLimits[LK64]
Durable mMedical eEquipment, pProsthetics, oOrthotics and cCertain sSupplies	Medical equipment, supplies or devices primarily and customarily used for medical purposes and not generally useful in the absence of illness or injury	Prior authorization is may be required. Refer to the Humana Healthy Horizons in Louisiana prior authorization listPAL for that has services that requiringe prior authorization.
Early Periodic Screening, Diagnostic, and Treatment (EPSDT) sServices	• Complete health and developmental history • Unclothed physical exam • Laboratory tests (including lead screening) • Immunizations (shots) • Screenings (including mental health, /depression,/ substance use,/ developmental, /hearing, /vision, / lead, other) • Dental screenings and referrals to dental providers • Nutrition • Health education and guidance • Referrals for further diagnosis (testing) and treatment when needed • Vision services • Dental services • Hearing services	Covered for members age 0 – 20
Emergency sServices	• Emergency service and care • Post-stabilization care after an emergency	No prior authorization required for emergency services.
End-s-Stage rRenal dDisease sServices	• Renal dialysis treatments (hemodialysis and peritoneal dialysis) • Routine laboratory services • Non-routine laboratory services • Medically necessary injections	

Eye cCare and vVision sServices	Members 0 through 20 • Examinations and treatment of eye conditions, including examinations for vision correction, refraction error • Regular eyeglasses when they meet a certain minimum strength requirementrequirement; m. Medically necessary specialty eyewear and contact lenses with prior authorization; cContact lenses are covered if they are the only means for restoring vision Members 21 and over • Examinations and treatment of eye conditions, such as infections, cataracts, etc. If the recipient has both Medicare and Medicaid, some vision related services may be covered. The recipient should contact Medicare for more information since Medicare would be the primary payer. • The recipient should contact Medicare for more information since Medicare would be the primary payer • Contact lenses are covered if they are the only means for restoring vision • The following services are covered as a value-added benefit: • 1 eEye exam per year • Up to $100 annual allowance for 1 set of glasses (frames and lenses) and/or contacts • Member pays any cost over $100 • Up to $100 annual allowance for 1 set of glasses (frames and lenses) and/or contacts • Member pays any cost over $100	Certain lLimits apply; pPrior authorization may be required. For more information: Contact Superior Vision at: www.superiorvision.comSuperior Vision or 1-800-504-3800877-235-5317 (general and utilization review) General or 1-855-313-3106 (Uutilization rReview) or or more information. for more information. Refer to the Humana Healthy Horizons in Louisiana prior authorizationPAL list for that has services that requiringe prior authorization. For mMembers age 21 and above+, some vision services are available as a value-added benefit.

Service/bBenefit	Covered sService/bBenefit	Limits/special instructionsLimits
Family pPlanning sServices	• Evaluation and management • Diagnostic services • Contraceptive services - Implantable contraceptive capsules - Diaphragm - Intrauterine contraceptives - Contraceptive supplies - Injectable contraceptives - Oral contraceptives	Covered for members age 10–59

~~Federally Qualified Health Center (~~**FQHC~~)~~/~~Rural Health Clinic (~~**RHC~~)~~ ~~s~~**Services**	• ~~Physician~~ Provider services • Services and supplies incident to a ~~physician's~~ provider's professional services • ~~Physician P~~~~rovider~~hysician assistant services • Nurse practitioner and nurse midwife services • Services and supplies incident to ~~physician~~ provider assistant, nurse practitioner and nurse midwife services • Visiting nurse services to the homebound • Clinical psychologist • Clinical social worker services[CC66][CS67] • Services and supplies incident to the services of clinical psychologists and clinical social workers • Other ambulatory services • Diabetes self-management training • Fluoride varnish applications	Not limited by Humana Healthy Horizons ~~in Louisiana~~
Freestanding p~~P~~sychiatric h~~H~~ospitals for a~~A~~dults	Medically necessary psychiatric inpatient care at freestanding psychiatric units~~.~~	Offered by Humana Healthy Horizons ~~in Louisiana~~ as an in lieu of service; p~~.~~ ~~P~~rior authorization ~~is~~ required~~.~~
Genetic counseling ~~Counseling~~ and t~~T~~esting	• Genetic counseling • Breast and ovarian cancer • ~~Familian~~Familial adenomatous polyposis • Lynch syndrome	Prior authorization ~~is~~may be required. Refer to the Humana Healthy Horizons ~~in Louisiana prior authorization list~~PAL for ~~that has~~ services ~~that~~ requiringe prior authorization.

Glasses, cContacts, and eEyew Wear	Members age 0 through 20 • Examinations and treatment of eye conditions, including examinations for vision correction, refraction error • Regular eyeglasses when they meet a certain minimum strength requirement. Medically necessary specialty eyewear and contact lenses with prior authorization. Contact lenses are covered if they are the only means for restoring vision • Contact lenses are covered if they are the only means for restoring vision Members age 21 and over • Examinations and treatment of eye conditions, such as infections, cataracts, etc. • If the recipient has both Medicare and Medicaid, some vision related services may be covered. The recipient should contact Medicare for more information since Medicare would be the primary payer The recipient should contact Medicare for more information since Medicare would be the primary payer • Contact lenses are covered if they are the only means for restoring vision • The following services are covered as a value-added benefit: • 1 Eye exam per year • Up to $100 annual allowance for 1 set of glasses (frames and lenses) and/or contacts • Member pays any cost over $100 •	Certain Limits apply. Prior authorization may be required Refer to the Humana Healthy Horizons in Louisiana prior authorization list that has services that require prior authorization For Members age 21+, some vision services are available as a value-added benefit.

Service/bBenefit	Covered sService/bBenefit	Limits/special instructionsLimits
Gynecology	The aArea of medicine that involvesinvolving the treatment of women's diseases, especially those of the reproductive organs Includes: • Hysterectomies • Long-acting reversible contraceptives • Mammograms • Pap smearstests • Pelvic examinations • Saline infusion sonohysterography or hysterosalpingography	Prior authorization may be required. Refer to the Humana Healthy Horizons in Louisiana prior authorization listPAL for that has services that requiringe prior authorization.
Home hHealth sServices	• Skilled nursing services • Home health aide services • Physical therapy • Occupational therapy • Speech-language pathology services	Prior authorization is required. Electronic vVisit vVerification compliance is required for claims payment.

	• Intermittent skilled nursing • Extended hHome hHealth (EHH) sServices • Extended sSkilled nNursing sServices	Prior authorization is required. Minimum of three 3 or more hours of nursing services per day may be provided to members under the age of 21 by the PAU. Electronic vVisit vVerification compliance is required for claims payment.
Hospice sServices	Comfort care for patients who are terminally ill, provided in their home or in a hospice facility when the member has elected hospice	Prior authorization is required
Hospital-based cCare cCoordination of pPregnant and pPostpartum iIndividuals with sSubstance uUse dDisorder and tTheir nNewborns	Coverage for a comprehensive medical home model of care to include: • Intake, aAssessment, cCare pPlan dDevelopment • Care cCoordination • Outreach for dDisengaged mMembers	Offered by Humana Healthy Horizons in Louisiana as an in lieu of service; nNo prior authorization is required. Individuals who are eligible for services must:Eligibility requirements (all 3 must be met): • Be Ppregnant or up to 12 months postpartum • Be 18 years of age or older and • Have Ssubstance use disorder May be subject to clinical claims review.
Hyperbaric oOxygen tTherapy	Treatments administered in a hyperbaric oxygen therapy chamber; if deemed medically necessary	
Injection sServices pProvided by lLicensed nNurses	Administration of injectable behavioral health medications by licensed nurses.	Offered by Humana Healthy Horizons in Louisiana as an in lieu of service; nNo prior authorization is required. May be subject to clinical claims review.
Immunizations	Vaccines for members age 0–18 are only covered when recommended by the Advisory Committee on Immunization Practices (ACIP). These vaccines are provided free of charge through the Louisiana Immunization Program/Vaccines for Children Program.For member's age 0–18, only cover vaccine administration for immunizations recommended by the Advisory Committee on Immunization Ppractices (ACIP). Vaccines for members age 0–18 are provided free of charge through the Louisiana Immunization Program/Vaccines for Children Pprogram. For members age 19 and older, should cover all ACIP-recommended vaccines, and vaccine administration, according to ACIP recommendations and without	Limitations apply depending on member's age

	restrictions or prior authorization	
Inpatient hHospital sServices	Care needed for the treatment of an illness or injury that, which can only be provided safely and adequately in a hospital setting and includes those basic services that a hospital is expected to provide: Inpatient hospital services may include: • Pre-admission certification and length of stay assignment • Distinct part psychiatric units • Obstetrical and gynecological services requiring special procedures • Sterilizations • Abortions • Dilation and curettage • Ectopic pregnancies • Molar pregnancies • Hysterectomies • Deliveries with non-payable sterilizations • Donor human milk • Other inpatient services • Mother,/ newborn, /nursery • Inpatient hospital definition of discharge • Discharge and readmit on the same day • Date of discharge or death • Out-of-state acute care hospitals • Rehabilitation units in acute care hospitals • Psychiatric diagnosis within an acute care • Gender affirming surgery • Rapid whole genome sequencing of critically ill infants	Prior authorization is required.
Intrathecal bBaclofen tTherapy	Used to help relax certain muscles in your the body, . It relievinges the spasms, cramping, and tightness of muscles caused by medical problems issues such as multiple sclerosis, cerebral palsy, or certain injuries to the spine: • Meningitis • Encephalitis • Dystonia	

	Multiple sclerosis • Spastic hemiplegia • Infantile cerebral palsy • Other specified paralytic syndromes • Acute, but ill-defined, cerebrovascular disease • Closed fracture of the base of skull • Open fracture of base of skull • Closed skull fracture • Fracture of vertebral column with spinal cord injury • Intracranial injury of other and unspecified nature • Spinal cord injury without evidence of spinal bone injury	
Laboratory and rRadiology sServices	• Most diagnostic testing and radiological services ordered by the attending or consulting physician. • Portable (mobile) Xx-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician provider-ordered Xx-rays. Advanced rRadiology: • X-ray (with or without contrast) • MRI (with or without dye) • CT/CAT scan • Magnetic angiography and imaging • Radiographic exams ••Ultrasound (endoscopic, echography, breast, abdominal, kidney, uterus, elastography)	Prior authorization is may be required.. Need to specify diagnostic testing requiring prior authorization. Not all labs should require prior authorization Refer to the Humana Healthy Horizons in Louisiana prior authorization listPAL for that has services that requiringe prior authorization.

Service/bBenefit	Covered sService/bBenefit	Limits/special instructionsLimits
Medical tTransportation sServices	Transportation to and from appointments for Medicaid covered services appointments	Managed by MediTrans, **1-.844-613-1638**, Monday – Friday, 7:00 a.m. to 7 :00 p.m. Mon-FridayNot limited by Humana Healthy Horizons (HHH) in Louisiana
Mental hHealth iIntensive oOutpatient pProgram (IOP)	Mental Health IOPs are covered to Aallow for an alternative to inpatient hospitalization or Assertive Community Treatment (ACT) and provide an option for step-down from inpatient hospitalization for members who are at high risk for readmission.	Offered by Humana Healthy Horizons in Louisiana as an in lieu of service; - pPrior authorization is required.
Newborn cCare and dDischarge	Educating new parents and caregivers on newborn care and safety. Includes:Newborn care and safety are the activities and precautions recommended for new parents or caregivers. It is also an educational goal of many hospitals and birthing centers when it's time to bring their infant home. • Discharge services • Newborn screenings for genetic disorders • Screening of all newborns for early detection of the cytomegalovirus (CMV) infection	

Obstetrics	Field of study concentrated on pregnancy, childbirth and the postpartum period Includes: • Initial prenatal visit(s) • Follow-up prenatal visits • Postpartum care visit • Prenatal laboratory and ultrasound services ~~• 17-alpha hydroxyprogesterone caproate~~ • Fetal non-stress test • Fetal biophysical profile • Tobacco cessation counseling during pregnancy • Remote patient monitoring	Prior authorization may be required. Refer to the Humana Healthy Horizons ~~in Louisiana prior authorization list that~~PAL for ~~has~~ services ~~that~~ requiring~~e~~ prior authorization. Prenatal services ~~should be~~ bill~~ed~~ with a TH modifier. Notification of deliveries that do not exceed 48-hour (vaginal)/96-hour (cesarean ~~C~~-section) standard time frames ~~is~~ encouraged to facilitate availability of Humana Healthy Horizons'~~s~~ discharge planning and case management services; p~~.~~ Prior authorization ~~is~~ not required unless those standard time frames are exceeded by delivery type~~.~~ Denial of p~~P~~ayments for deliveries occurring before 39 weeks without a medical indication ~~will be denied.~~
Opioid t~~T~~reatment p~~P~~rogram (OTP)	A program or practitioner engaged in opioid treatment of individuals with an opioid agonist medication~~.~~ Coverage for medically necessary m~~M~~edication-a~~A~~ssisted t~~T~~reatment (MAT) delivered in ~~Opioid Treatment Programs (~~OTPs~~)~~, including but not limited to m~~M~~ethadone treatment to all Medicaid-eligible adults and adolescents with o~~O~~pioid u~~U~~se d~~D~~isorder (OUD)~~.~~	Members who meet clinical criteria must be at least 18 years old, unless the member has consent from a parent or legal guardian, if applicable, and the State Opioid Treatment Authority~~.~~
Outpatient h~~H~~ospital s~~S~~ervices	Care provided in an outpatient hospital setting for less than 24 hours: • Therapeutic and diagnostic services • Proton beam therapy • Emergency room (ER) services • Hospital laboratory services • Hyperbaric oxygen therapy • Long-acting reversible contraceptives in the outpatient hospital setting • Outpatient rehabilitation services • Outpatient surgery • Intraocular lens implants • Observation room charges • Outpatient hospital clinic services	Prior authorization may be required.~~-~~ Refer to the Humana Healthy Horizons ~~in Louisiana prior authorization list that has~~PAL for services ~~that~~ requiring~~e~~ prior authorization.

Pediatric dDay hHealthcare sServices	Services include: • Nursing care • Respiratory care • Physical therapy • Speech-language therapy • Occupational therapy • Social services • Personal care services (activities of daily living [ADL]) • Transportation to and from the Pediatric Day HealthyCcare facility, . Transportation shall be paid in a separate per diem.	Covered for members age 21 years old and younger when0 – 20 years of age when medically necessary; p. Prior authorization is required.
Personal cCare sServices	Provision of medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age- appropriate instrumental activities of daily livingADL (IADL) to enable members to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability. Including: daily living (ADL) and age appropriateage- appropriate instrumental activities of daily living (IADL) to enable members to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability. • Basic personal care-toileting and& grooming activities • Assistance with bladder and/or bowel requirements or problems • Assistance with eating and food preparation • Performance of incidental household chores, only for the recipient • Accompanying, not transporting, recipient to medical appointments	Prior authorization is required for both EPSDT pPersonal cCare sServices (age 0 – 20) and bBehavioral hHealth pPersonal cCare sServices (adults with sSerious mMental iIllness, age 21 and above+). Electronic vVisit vVerification compliance is required for claims payment.
Pharmacy sServices	Prescription medications	Prior authorization may be required.

Service/bBenefit	Covered sService/bBenefit	Limits/special instructionsLimits
Podiatry services	Office visits, certain radiology and lab procedures and other diagnostic procedures	Prior authorization may be required. Refer to the Humana Healthy Horizons PAL for services requiring prior authorization.
Preventive services for adults	Screenings, checkups and member counseling, from PCPs or specialists, to prevent illness, disease or other health problems	Prior authorization may be required. Refer to the Humana Healthy Horizons PAL for services requiring prior authorization.
Physician Provider-aAdministered mMedication	Physician Provider-administered drugs and biologicals	Prior authorization may be required regardless of setting.

PhysicianProvider/pProfessional sServices	Professional medical services includes: • Physician Provider services • Nurse midwife • Nurse practitioner • Clinical nurse specialists • Physician Provider assistant • Certain family planning services are covered when provided in a physician's provider's office • Telemedicine/tTelehealth	Prior authorization may be required. Refer to the Humana Healthy Horizons in Louisiana prior authorization list that hasPAL for services that requiringe prior authorization.
Podiatry sServices	Office visits, certain radiology and lab procedures and other diagnostic procedures	Prior authorization may be required Refer to the Humana Healthy Horizons in Louisiana prior authorization list that hasPAL for services that requiringe prior authorization
Preventive sServices for aAdults	Screenings, check-ups and member counseling, from primary care providersPCPs or specialists, to prevent illness, disease or other health problems	Prior authorization may be required Refer to the Humana Healthy Horizons in Louisiana prior authorization list that hasPAL for services that requiringe prior authorization
Psychiatric Residential Treatment Facilities (PRTFs)	Medically mMonitored, hHigh-iIntensity iInpatient tTreatment: • Psychiatric and substance use assessments • Diagnosis treatment • Habilitative and rehabilitation services Habilitative and rehabilitation services	Covered for members under the age of 21.
Remote pPatient mMonitoring	The use of medical devices to measure and transmit health data from an enrollee member to a provider for the management of hypertension and diabetes for pregnant enrolleesmembers.	Offered by Humana Healthy Horizons as an in lieu of service
Routine cCare pProvided to mMembers pParticipating in cClinical tTrials	Cover any item or service provided to a member participating in a qualifying clinical trial to the extent that the item or service would otherwise be covered for the member when not participating in the qualifying clinical trial, . This includinges any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation	

Skilled nNursing fFacility care	Medically necessary skilled nursing care provided in a licensed sSkilled nNursing fFacility outside of the sState of Louisiana's lLong-t-Term cCare program.	Offered by Humana Healthy Horizons in Louisiana as an in lieu of service.; p Prior authorization is required.
Sterilization	Medically necessary procedure to permanently render a member incapable of reproducing	Eligibility requirements: • The individual is at least 21 years of age at the time the consent is obtained. • The individual is not a mentally incompetent. individual • The individual has voluntarily given informed consent in accordance with all federal requirements. • At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since a member gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Service/bBenefit	Covered sService/bBenefit	Limits/special instructionsLimits
Telemedicine/tTelehealth	The distribution of health-related services and information via electronic information and telecommunication technologies, . It allowings long--distance patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions	
Therapeutic Group Homes (TGHs)	• Psychiatric supports, • Therapeutic services (individual counseling, family therapy, and group therapy) • Skill-building, preparinges the youth to return back to their community	Covered for members under the age of 21, who are under the supervision and program oversight of a psychiatrist or psychologist.

Therapy sServices	• Audiological sServices (aAvailable in rehabilitation cClinic and outpatient hHospital- Outpatient settings only.) • Occupational tTherapy • Physical tTherapy • Speech- & Language tTherapy	Prior authorization is required
Tobacco cCessation sServices	The process of discontinuing tobacco smokinguse. Smoking cessation treatments and services, including individual and group counseling; nicotine patches, gum, lozenges, nasal spray and inhaler; bupropion; and varenicline~~Smoking cessation treatments and services, including individual counseling, group counseling, nicotine patches, nicotine gum, nicotine lozenges, nicotine nasal spray, nicotine inhaler, bupropion, and varenicline.~~	Available to all members~~s.~~ Coverage for smoking cessation benefits for a minimum period of ~~six~~6 months.
Vagus nNerve sStimulators (VNSs)	Medical treatment ~~that involves~~ delivering electrical impulses to the vagus nerve. ~~. It is~~ used as an add-on treatment for certain types of intractable epilepsy and treatment-resistant depression. • ~~Vagus nerve stimulator (~~VNS~~)~~ • Implantation of the VNS • Programming of the VNS • Battery replacement	

Allergy tTesting and aAllergen iImmunotherapy

Humana Healthy Horizons ~~in Louisiana~~ covers allergy testing and allergen immunotherapy relating to hypersensitivity disorders manifested by generalized systemic reactions as well as by localized reactions in any organ system of the body. Covered allergy services ~~shall~~ include:

- In vitro ~~-~~specific IgE tests
- Intracutaneous (intradermal) skin tests
- Percutaneous skin tests
- Ingestion challenge testing
- Allergen immunotherapy

Humana Healthy Horizons ~~in Louisiana~~ covers allergy testing for members who have symptoms of allergic disease, such as respiratory ~~symptoms~~, skin ~~symptoms,~~ or other symptoms that consistently follow a particular exposure, not including local reactions after an insect sting or bite. Humana Healthy Horizons ~~in Louisiana will~~ covers allergen immunotherapy at:

- A minimum of 180 doses every calendar year, per member, for supervision of preparation and provision of antigens other than stinging or biting insects
- A minimum of 52 doses every calendar year, per member, for supervision of preparation and provision of antigens related to stinging or biting insects; allergen immunotherapy doses exceeding the above quantities when medically necessary ~~shall be~~are covered

Cardiovascular sServices

Humana Healthy Horizons ~~in Louisiana~~ covers elective iInvasive cCoronary aAngiography (ICA) and pPercutaneous cCoronary iIntervention (PCI) as treatment for cardiovascular conditions under specific circumstances.

The following are not eligible for these services: ~~This policy only applies to members age 18 and older and does not apply to the following members:~~

- Members uUnder the age of 18
- Pregnant members
- Cardiac transplant ~~members~~survivors
- Solid organ transplant candidates
- Survivors of sudden cardiac arrest

Eligibility cCriteria for eElective ICA

Humana Healthy Horizons ~~in Louisiana~~ covers elective ICA and considers it medically necessary in members with ~~one~~ 1 or more of the following:

- Congenital heart disease that cannot be characterized by non-invasive modalities such as cardiac ultrasound, CT~~,~~ scan or MRI
- Heart failure with reduced ejection fraction for the purposes of diagnosing ischemic cardiomyopathy~~;~~
- Hypertrophic cardiomyopathy prior to septal ablation or myomectomy
- Severe valvular disease or valvular disease with plans for surgery or percutaneous valve replacement

- Type 1 myocardial infarction within the past ~~three~~ 3 months defined by detection of a rise and/or fall of cardiac troponin values with at least ~~one~~ 1 value above the 99th percentile upper reference limit and with at least ~~one~~ 1 of the following:
  - Symptoms of acute myocardial ischemia
  - New ischemic electrocardiogram (ECG) changes
  - Development of pathological Q waves
  - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality in a pattern consistent with an ischemic etiology
  - Identification of a coronary thrombus
- History of ventricular tachycardia requiring therapy for termination or sustained ventricular tachycardia not due to a transient reversible cause, within the past year~~;~~
- History of ventricular fibrillation
- Return of angina within ~~nine~~ 9 months of prior PCI
- ~~Members without chronic kidney disease who have~~ Canadian Cardiovascular Society (CCS) class I~~–~~IV classification of angina, without chronic kidney disease, with intolerance of or failure to respond to at least ~~two~~ 2 target dose~~s~~ anti~~-~~anginal medications (beta blocker~~s~~, dihydropyridine or non~~-~~dihydropyridine calcium channel blocker~~s~~, nitrate~~s~~~~,~~ and/or ranolazine)
- High~~-~~risk imaging findings, defined as ~~one~~ 1 or more of the below:
  - Severe resting left ventricular dysfunction (LVEF ≤ 35%) not readily explained by noncoronary causes
  - Resting perfusion abnormalities ≥ 10% of the myocardium in members without prior history or evidence of myocardial infarction
  - Stress ~~electrocardiogram~~ ECG findings including ≥2 mm of ST-segment depression at low workload
  - P~~p~~ersisting into recovery, exercise-induced ST-segment elevation~~,~~ or exercise-induced ventricular tachycardia/ ventricular fibrillation
  - Severe stress-induced left ventricular dysfunction (peak exercise LVEF < 45% or drop in LVEF with stress ≥ 10%)
  - Stress-induced perfusion abnormalities affecting ≥ 10% myocardium or stress segmental scores indicating multiple vascular territories with abnormalities
  - Stress-induced left ventricular dilation
  - Inducible wall motion abnormality (involving > 2 segments or 2 coronary beds)
  - Wall motion abnormality developing at a low dose of dobutamine (≥ 10 mg/kg/min) or at a low heart rate (< 120 beats per minute~~/ min~~)
  - Left main stenosis (≥ 50% stenosis) on coronary computed tomography angiography
  - ICA for non-acute, stable coronary artery disease is not considered medically necessary, including for patients with stable angina who are not interested in revascularization or who are not candidates for PCI or coronary artery bypass graft surgery.
  -

Eligibility c~~C~~riteria for e~~E~~lective PCI

Humana Healthy Horizons ~~in Louisiana~~ covers elective PCI for angina with stable coronary artery disease and considers it medically necessary in members without chronic kidney disease who have ~~Canadian Cardiovascular Society~~CCS class I~~–~~IV ~~classification of~~ angina with intolerance of or failure to respond to at least two target dose~~s~~ anti~~-~~anginal medications (beta blocker~~s~~, dihydropyridine or non~~-~~dihydropyridine calcium channel blocker~~s~~, nitrate~~s~~~~,~~ and/or ranolazine).

Elective PCI for other cardiac conditions is considered medically necessary in members with ~~one~~ 1 or more of the following:

- Heart failure with reduced ejection fraction for the purposes of treating ischemic cardiomyopathy
- Left main stenosis ≥ 50% as determined on prior cardiac catheterization or coronary computed tomography angiography, if the member has documentation indicating the member was~~y were~~ declined for a coronary artery bypass graft surgery
- Type 1 myocardial infarction within the past ~~three~~ 3 months as defined by detection of a rise and/or fall of cardiac troponin values with at least ~~one~~ 1 value above the 99th percentile upper reference limit and with at least ~~one~~ 1 of the following:
  - Symptoms of acute myocardial ischemia
  - New ischemic ~~electrocardiogram~~ ECG changes
  - Development of pathological Q waves

- Imaging evidence of a new loss of viable myocardium~~,~~ or new regional wall motion abnormality in a pattern consistent with an ischemic etiology
- Identification of a coronary thrombus

Elective PCI for non~~-~~acute, stable~~,~~ coronary artery disease is not considered medically necessary in all other member populations, including if the member is unwilling to adhere ~~with~~ to recommended medical therapy~~,~~ or if the member is unlikely to benefit from the proposed procedure (e.g., life expectancy less than ~~six~~ 6 months due to a terminal illness).

Endovascular rRevascularization for pPeripheral aArtery dDisease
Humana Healthy Horizons ~~in Louisiana~~ covers endovascular revascularization procedures (stents, angioplasty~~,~~ and atherectomy) for the lower extremity and considers them medically necessary for the following conditions:
· Acute limb ischemia
· Chronic limb-threatening ischemia, defined as the presence of any of the following:
  - Ischemic pain at rest
  - Gangrene
  - Lower limb ulceration greater than ~~two~~ 2 weeks duration

Humana Healthy Horizons ~~in Louisiana~~ also covers endovascular revascularization procedures and considers them medically necessary in members with peripheral artery disease who have symptoms of intermittent claudication and meet all of the following criteria:
· Significant peripheral artery disease of the lower extremity as indicated by at least ~~one~~ 1 of the following:
  - Moderate to severe ischemic peripheral artery disease with an ankle-brachial index (ABI) ≤ 0.69
  - ~~-~~Stenosis in the aortoiliac artery, femoropopliteal artery, or both arteries, with a severity of stenosis ≥ 70% by imaging studies
- Claudication symptoms that impair the ability to work or perform ~~activities of daily living~~ADL
- No improvement of symptoms despite all of the following treatments:
  - Documented participation in a medically supervised or directed exercise program for at least 12 weeks
  - ~~-~~Individuals ~~fully~~ unable to fully perform exercise therapy ~~fully~~ may qualify for revascularization only if the procedure is expected to provide long-term functional benefits despite the limitations that precluded exercise therapy.
  - At least ~~six~~ 6 months of optimal pharmacologic therapy including all of the below agents, unless contraindicated or discontinued due to adverse effects:
    - Antiplatelet therapy with aspirin, clopidogrel, or both
    - Statin therapy
    - Cilostazol
    - Antihypertensives to a goal systolic blood pressure ≤ 140 mmHg and diastolic blood pressure ≤ 90 mmHg
  - At least ~~one~~ 1 documented attempt at smoking cessation, if applicable, consisting of pharmacotherapy, unless contraindicated, and behavioral counseling, or referral to a smoking cessation program that offers both pharmacotherapy and counseling

Exclusions
Humana Healthy Horizons ~~in Louisiana~~ does not consider endovascular revascularization procedures for the lower extremity ~~not~~ medically necessary in the following circumstances:
· Claudication due to isolated infrapopliteal artery disease (anterior tibial, posterior tibial or peroneal) including members with coronary artery disease, diabetes ~~mellitus~~, or both
· To prevent the progression of claudication to chronic limb-threatening ischemia in a member who does not otherwise meet medical necessity criteria
· Member is asymptomatic
· Treatment of a nonviable limb

Peripheral aArterial dDisease rRehabilitation for sSymptomatic pPeripheral aArterial dDisease
Peripheral arterial disease rehabilitation, also known as supervised exercise therapy, involves the use of intermittent exercise training for the purpose of reducing intermittent claudication symptoms.

Humana Healthy Horizons ~~in Louisiana~~ covers and considers medically necessary up to 36 sessions of peripheral arterial disease rehabilitation annually. Delivery of these sessions ~~three~~ 3 times per week over a 12-week period is recommended~~,~~ but not required. Humana Healthy Horizons ~~in Louisiana~~ will direct providers to adhere to Current Procedural Terminology (CPT®) guidance on the time per session, exercise activities permitted~~,~~ and the qualifications of the supervising provider.

Cochlear iImplant
Humana Healthy Horizons ~~in Louisiana~~ covers unilateral or bilateral cochlear implants for members under 21 years of age when deemed medically necessary for treatment of severe-to-profound, bilateral sensorineural hearing loss. Implants must be used in accordance with ~~Food and Drug Administration (~~FDA~~)~~ guidelines.

Eligibility cCriteria
A multidisciplinary implant team must collaborate to determine eligibility and ~~to~~ provide care. This team must include,

at minimum, a fellowship-trained pediatric otolaryngologist or fellowship trained otologist, an audiologist, and a speech-

language pathologist.

An audiological evaluation must find:
- Severe-to-profound hearing loss determined through the use of an age-appropriate combination of behavioral and physiological measures
- Limited or no functional benefit achieved after a sufficient trial of hearing aid amplification

A medical evaluation must include:
- Medical history
- Physical examination verifying the candidate has intact tympanic membrane(s), is free of active ear disease, and has no contraindication for surgery under general anesthesia
- Verification of receipt of all recommended immunizations
- Verification of accessible cochlear anatomy that is suitable to implantation, as confirmed by imaging studies (computed tomography (CT scan) and/or magnetic resonance imagery (MRI)), when necessary
- Verification of auditory nerve integrity, as confirmed by electrical promontory stimulation, when necessary

For bilateral cochlear implants, an audiologic and medical evaluation must determine that a unilateral cochlear implant plus hearing aid in the contralateral ear will not result in binaural benefit for the member.
Non-audiological evaluations must include:
- Speech and language evaluation to determine the member's level of communicative ability
- Psychological and/or social work evaluation, as needed.

Pre-operative counseling must be provided to the member, if age appropriate, and the member's caregiver and must provide:
- Information about implant components and function; risks, limitations, and potential benefits of implantation; the surgical procedure; and a postoperative follow-up schedule
- Appropriate post-implant expectations, including being prepared and willing to participate in pre- and post-implant assessment and rehabilitation programs
- Information about alternative communication methods to cochlear implants.

Preoperative eEvaluation
When prior authorized, Humana Healthy Horizons in Louisiana will reimburse preoperative evaluation services (i.e., evaluation of speech, language, voice, communication, auditory processing, and/or audiologic/aural rehabilitation) even when the member may not subsequently receive an implant.

Implants, eEquipment, rRepairs, and rReplacements
Humana Healthy Horizons in Louisiana will make reimbursement to the hospital at the time of surgery for both the implant and the per diem. The implant and the implantation surgery must be preior authorized by submitting the PA-01 form. After approval has been granted, the hospital must bill for the implant(s) by submitting the appropriate Healthcare Common Procedure Coding System (HCPCS) code on a CMS 1500 claim form. Write the letters DME in bold, black print on the top of the form and the prior authorization PA number written in item 23.

Humana Healthy Horizons in Louisiana will covers:
- All costs for upgrades and repairs to the component parts of the implant
- All costs for cords and batteries

Implantation pProcedure, pPostoperative rRehabilitative cCosts, and sSubsequent tTherapy
Humana Healthy Horizons in Louisiana covers the cochlear implant surgery as well as postoperative aural rehabilitation by an audiologist and subsequent speech, language, and hearing therapy.

Posto-Operative pProgramming
Humana Healthy Horizons in Louisiana covers cochlear implant post-operative programming and diagnostic analysis services.

Noncovered eExpenses
The following items are non-covered expenses:
- Service contracts and/or extended warranties; and
- Insurance to protect against loss and theft

Community hHealth wWorkers
Humana Healthy Horizons in Louisiana will covers services rendered to members by qualified community health workers (CHWs) meeting the criteria and policy outlined below.

A qualified ~~Community Health Worker~~CHW is defined as someone who:

- Has completed state-recognized training curricula approved by the Louisiana Community Health Worker Workforce Coalition~~.~~
- Has a minimum of 3,000 hours of documented work experience as a CHW. ~~ABHLA~~ Humana Healthy Horizons ~~in Louisiana~~ will require providers who employ CHWs to verify, maintain~~,~~ and provide documentation, as requested, ~~by LDH,~~ that qualification criteria are ~~met~~met~~.~~

Eligibility c~~C~~riteria

Humana Healthy Horizons ~~in Louisiana will~~ covers CHW services if a member has ~~one~~ 1 or more of the following:

- Diagnosis of ~~one~~ 1 or more chronic health (including behavioral health) conditions
- Suspected or documented unmet health-related social need(s)
- Pregnancy

Covered services include:

- Health promotion and coaching: ~~.~~ This can include assessment and screening for health-related social needs, setting goals and creating an action plan; on-site observation of member's living situation~~s~~~~;~~ and providing information and/or coaching in an individual or group setting.
- Care planning with the member and the member's ~~ir~~ healthcare team: ~~.~~ This should occur as part of a person-centered approach to improve health by meeting a member's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention.
- Health system navigation and resource coordination services: ~~.~~ This can include helping to engage, reengage~~,~~ or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions.

Services must be ordered by a ~~physician~~provider, ~~advanced practice registered nurse (~~APRN~~),~~ or ~~physician~~ provider assistant ~~(PA)~~ with an established clinical relationship with the member. Services must be rendered under this supervising provider's general supervision, defined as under the supervising provider's overall direction and control, but the provider's presence is not required during the performance of the CHW services.

Humana Healthy Horizons ~~in Louisiana~~ will not restrict the site of service, which may include, but is not limited to, a health ~~c~~care facility, clinic setting, community setting~~,~~ or the member's home. The health plan will permit delivery of the service through a synchronous audio ~~/~~video telehealth modality. Humana Healthy Horizons ~~in Louisiana~~ will reimburse only the ~~CPT procedure codes in the "'Education and Training for Patient Self-Management"' section~~ applicable codes that are provided by CHWs. The CHWs are required to follow CPT guidance.

Coverage l~~L~~imitations

Humana Healthy Horizons ~~in Louisiana~~ does~~will~~ not cover the following services when provided by CHWs:

- Insurance enrollment and insurance navigator assistance~~;~~
- Case management
- Direct provision of transportation for a member to and from services
- Direct patient care outside the level of training an individual has attained

Humana Healthy Horizons ~~in Louisiana~~ will reimburse a maximum of ~~two~~ 2 hours per day and ~~ten~~ 10 hours per month per member.

Reimbursement

Humana Healthy Horizons ~~in Louisiana~~ will reimburse CHW services "incident to" the supervising ~~physician~~provider, APRN~~,~~ or provider assistant~~PA~~. A CHW who provides services to more than ~~one~~ 1 member is required to document in the clinical record and bill appropriately using the approved codes associated with the number of people receiving the service simultaneously. This ~~shall be~~is limited to ~~eight~~ 8 unique members per session.

Donor h~~H~~uman m~~M~~ilk

Humana Healthy Horizons ~~in Louisiana~~ covers donor human milk provided in the inpatient hospital setting for certain medically vulnerable infants. This coverage ~~shall be~~is provided without restrictions or the requirement for prior authorization. Donor human milk is considered medically necessary when all of the following criteria are met:

- The hospitalized infant is less than 12 months of age with ~~one~~ 1 or more of the following conditions:
    - Prematurity
    - Malabsorption syndrome
    - Feeding intolerance

- Immunologic deficiency
- Congenital heart disease or other congenital anomalies;

- Other congenital or acquired condition that places the infant at high risk of developing necrotizing enterocolitis (NEC) and/or infection

- The infant's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding.
- The infant's caregiver has received education on donor human milk, including the risks and benefits, and agrees to the provision of donor human milk to their infant.
- The donor human milk is obtained from a milk bank accredited by, and in good standing with, the Human Milk Banking Association of North America.

Reimbursement

Humana Healthy Horizons in Louisiana reimburses donor human milk separately from the hospital reimbursement for inpatient services. The minimum reimbursement for the donor human milk is the fee on file on the Louisiana Medicaid Durable Medical Equipment (DME) Fee Schedules.

Hospitals must bill the donor human milk claim using the Healthcare Common Procedure Coding System (HCPCS) procedure code T2101 (1 unit per ounce) on a CMS 1500 claim form.

Early Periodic Screening, Diagnostic, and Treatment (EPSDT) sServices

Effective with for dates of service on and after Nov.ember 1, 2021, Louisiana Medicaid will no longer reimburse EPSDT preventive screening visits appended with modifier 'TD'. Claims for preventive screening visits submitted to fee for service or Humana Healthy Horizons in Louisiana appended with modifier 'TD' will be deniedy. This denial also will also apply to Humana Healthy Horizons in Louisiana encounters.

The physicianprovider, advanced practice registered nurseAPRN, or physician provider assistant listed as the rendering provider must be present and involved during the preventive screening visit. Any care provided by a registered nurse (RN) in the office or outpatient setting is subject to Medicaid's "Incident to" policy.

This clarification reiterates Medicaid's long-standing intention and support that fee-for-service providers and Humana Healthy Horizons in Louisiana and their provider's mainstream Medicaid beneficiaries into the same models and standards of care as individuals with other types of insurance.

General aAnesthesia/f Facility rReimbursement hHospital for dDental tTreatment

Humana Healthy Horizons in Louisiana will covers general anesthesia for dental treatment — it is a necessary part of surgical services for some children and, when clinically indicated, for individuals with intellectual and developmental disabilities.

Reimbursement

- Anesthesia providers will receive an additional reimbursement of $20.00 per time unit (each time unit is equal to 15 minutes).
- To receive the additional reimbursement, the provider must append modifier 2 23 to the anesthesia CPT code 00170 in addition to othero other appropriate anesthesia modifiers when a dental procedure is performed.
- The general anesthesia reimbursement formula has been revised to calculate the additional reimbursement.
- reimbursement. The additional reimbursement will be applied after all other calculations take place.
- Facilities can receive an additional reimbursement of at least $400.00 per procedure.
- For hospital providers to receive the additional reimbursement, CPT code 41899 must be used. To qualify for the enhanced reimbursement, the procedure must take place in a hospital outpatient setting.

Pain management

Epidurals are covered for the administration for and prevention or control of acute pain that occurs during delivery or surgery, as professional services for this purpose only.

For cChronic iIntractable pPain, coverage is dependent on the clinical etiology and the type of service or treatment.

Genetic cCounseling and tTesting

Genetic testing for a particular disease should generally be performed once per lifetime; however, there are rare instances in which testing may be performed more than once in a lifetime (e.g., previous testing methodology is inaccurate or a new discovery has added significant relevant mutations for a disease).

relevant mutations for a disease).

Genetic cCounseling

In alignment with LDH policy, Humana Healthy Horizons ~~in Louisiana~~ requires counseling before and after all genetic

testing. Counseling must consist of at least all of the following and be documented in the member's medical record:

- Obtaining a structured family genetic history
- Performing a genetic risk assessment
- Counseling of the beneficiary and family about diagnosis, prognosis, and treatment

When performed by licensed genetic counselors, Humana Healthy Horizons in Louisiana shallwill reimburse services using the procedure code specific to genetic counseling. Reimbursement for this service is "incident to" the services of a supervising physician provider and is limited to no more than 90 minutes on a single day of service.

When performed by providers other than licensed genetic counselors, Humana Healthy Horizons in Louisiana shallwill reimburse for counseling under an applicable evaluation and management code.

Breast and oOvarian cCancer

Humana Healthy Horizons in Louisiana shall cover and consider genetic testing for BRCA1 and BRCA2 mutations in cancer-affected individuals and cancer-unaffected individuals to be medically necessary if the member meets the criteria listed below.

Eligibility cCriteria

Individuals meeting one 1 or more of the below criteria are considered eligible:.

- Has any blood relative with a known BRCA1/BRCA2 mutation
- Meets the criteriaI below but with previous limited testing (e.g., single gene and/or absent deletion duplication analysis) interested in pursuing multi-gene testing
- Has a personal history of cancer, defined as one of more of the following::
  - Breast cancer and one 1 or more of the following:
    - Diagnosed at age 45 or younger
    - Diagnosed at age 45 – 50 with:
      - Unknown or limited family history
      - A second incidence of breast cancer diagnosed at any age
    - At least one 1 close blood relative with breast, ovarian, pancreatic, or high-grade (Gleason score of at least 7) or intraductal prostate cancer at any age
  - Diagnosed with triple negative breast cancer at age 60 or younger
  - Diagnosed at any age with:
    - Ashkenazi Jewish ancestry
    - At least one 1 close blood relative with breast cancer at under 50 years of age or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age
    - At least three 3 total diagnoses of breast cancer in patient and/or close blood relatives
  - Diagnosed at any age with male breast cancer
  - Diagnosed with eEpithelial ovarian cancer (including fallopian tube cancer or peritoneal cancer) at any age
  - Exocrine pancreatic cancer at any age
  - Metastatic or intraductal prostate cancer at any age
  - High-grade (Gleason score of at least 7) prostate cancer at any age with:
    - Ashkenazi Jewish ancestry
    - At least one 1 close blood relative with breast cancer diagnosed at age 50 or younger, or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age
    - At least two 2 close blood relatives with breast or prostate cancer (any grade) at any age
  - A mutation identified on tumor genomic testing that has clinical implications if also identified in the germ line
  - To aid in systemic therapy decision-making, such as for HER2-negative metastatic breast cancer
  - Individuals withHas a family history of cancer, including unaffected individuals, defined by 1one or more of the following:
    - An affected or unaffected individual with a 1st- or 2nd-degree blood relative meeting any of the criterion listed above (except individuals who meet criteria only for systemic therapy decision-making)
    - An affected or unaffected individual who otherwise does not meet criteria above but also has a probability > 5% of a BRCA1/BRCA2 pathogenic variant based on prior probability models (e.g., Tyrer-Cuzick, BRCAPROro, Penn IIII)

Prenatal vVisits

The MCO shallHumana Healthy Horizons in Louisiana will covers 2 two initial prenatal visits per pregnancy (270 days). These two 2 visits may not be performed by the same attending provider.

The MCO shallHumana Healthy Horizons in Louisiana will consider the enrolleemember a "'new patient"' for each pregnancy

whether or not the ~~enrollee~~member is a new or

established patient to the provider/practice. ~~The MCO shall~~Humana Healthy Horizons ~~in Louisiana~~ require~~s~~ ~~that~~ billing the appropriate level Evaluation and Management (E&M) CPT ~~procedure~~ code ~~be billed for the initial prenatal visit~~ with the TH modifier for the initial prenatal visit. A pregnancy-related diagnosis code also must ~~also~~ be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, ~~which must be modified with TH, shall~~ include~~s~~, but is not limited to, the following:

- Estimation of gestational age by ultrasound or firm last menstrual period
  - ~~(~~If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy below.~~)~~
- Identification of patient at risk for complications including those with prior preterm birth
- Health and nutrition counseling
- Routine dipstick urinalysis~~.~~

If the pregnancy is not verified, or if the pregnancy test is negative, the service may only be submitted with the appropriate level E&M without the TH modifier. Healthy Horizons ~~in Louisiana The MCO~~ may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.

Obstetric u~~U~~ltrasounds

A minimum of ~~three~~ 3 obstetric ultrasounds ~~shall~~ will be reimbursed per pregnancy (270 days) without the requirement of prior authorization or medical review when performed by providers other than maternal fetal medicine specialists:

- When an obstetric ultrasound is performed for an individual with multiple gestations, leading to more than ~~one~~ 1 procedure code being submitted, this ~~shall~~ will only be counted as ~~one~~ 1 obstetric ultrasound~~.~~
- Obstetric ultrasounds performed in inpatient hospital, emergency department~~,~~ and labor and delivery triage settings are excluded from this count~~.~~

For maternal fetal medicine specialists, ~~there shall be~~ no prior authorization or medical review is required for reimbursement of obstetric ultrasounds. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. In all cases, obstetric ultrasounds must be medically necessary to be eligible for reimbursement.

Prenatal services should be billed with a TH modifier.

Fetal non~~-~~stress test

~~The MCO shall~~Humana Healthy Horizons ~~in Louisiana will~~ cover~~s~~ fetal non~~-~~stress tests when medically necessary as determined by meeting ~~one~~ 1 of the following criteria:

- The pregnancy is post~~-~~date/post~~-~~maturity (after 41 weeks gestation)
- The treating provider suspects potential fetal problems in an otherwise normal pregnancy
- The pregnancy is high risk, including but not limited to diabetes ~~mellitus~~, pre~~-~~eclampsia, eclampsia, multiple gestations~~,~~ and previous intrauterine fetal death~~.~~

Fetal b~~B~~iophysical p~~P~~rofile

~~The MCO shall~~Humana Healthy Horizons ~~in Louisiana will~~ cover~~s~~ fetal biophysical profiles when medically necessary, as determined by meeting at least ~~two~~ 2 of the following criteria:

- Gestation period is at least 28 weeks
- Pregnancy must be high ~~-~~risk, and if so, the diagnosis should reflect high risk
- Uteroplacental insufficiency must be suspected in a normal pregnancy

Pharmacy s~~S~~ervices

You can find a more comprehensive description of covered services at~~in~~ Prime Therapeutics State Government Solutions (Prime Therapeutics). [DB68]~~Magellan Medicaid Administration.Pharmacy Management.~~

~~Physician~~Provider/p~~P~~rofessional s~~S~~ervices

Effective for dates of service on or after May 1, 2021, fees for inpatient neonatal critical care services have been updated. Previously paid claims with dates of service on or after the effective date will be recycled with no action needed by the provider.

Humana Healthy Horizons ~~in Louisiana~~ must update ~~their~~ its claims processing system~~s~~ within 30 days. Humana Healthy Horizons ~~in Louisiana shall~~will recycle claims paid on or after May 1, 2021, to pay at the updated rate, and will notify impacted providers.

Sinus p~~P~~rocedures p~~P~~olicy

Balloon ostial dilation and functional endoscopic sinus surgery are considered medically necessary for the treatment of chronic rhinosinusitis when all of the following criteria are met:

- Uncomplicated chronic rhinosinusitis limited to the paranasal sinuses without the involvement of adjacent neurological,

~~neurological,~~ soft tissue~~,~~ or bony structures that has persisted for at least 12 weeks with at least ~~two~~ 2 of the following sinonasal symptoms:

- Facial pain/pressure
- Hyposmia/anosmia
- Nasal obstruction
- Mucopurulent nasal discharge

· Sinonasal symptoms that are persistent after maximal medical therapy has been attempted, as defined by all of the following, either sequentially or overlapping:

- Saline nasal irrigation for at least ~~six~~ 6 weeks
- Nasal corticosteroids for at least ~~six~~ 6 weeks
- Approved biologics, if applicable, for at least ~~six~~ 6 weeks
- A complete course of antibiotic therapy when an acute bacterial infection is suspected
- Treatment of concomitant allergic rhinitis, if present

· Objective evidence of sinonasal inflammation as determined by ~~one~~ 1 of the following:

- Nasal endoscopy
- Computed tomography

Balloon ostial dilation and functional endoscopic sinus surgery are not covered and not considered medically necessary in the following situations:

· Presence of sinonasal symptoms but no objective evidence of sinonasal disease by nasal endoscopy or computed tomography
· For the treatment of obstructive sleep apnea and/or snoring when the above criteria are not met
· For the treatment of headaches when the above criteria are not met
· For balloon ostial dilation only, when sinonasal polyps are present

Skin ~~s~~Substitutes for c~~C~~hronic d~~D~~iabetic l~~L~~ower e~~E~~xtremity u~~U~~lcers

Skin substitutes are covered for the treatment of partial- and full-thickness diabetic lower extremity ulcers when the member meets all of the following requirements:

· A lower extremity ulcer is present:

- Is at least 1~~.0~~ square ~~centimeter (~~cm~~)~~ in size
- Has persisted for at least 4 weeks
  - Has not demonstrated measurable signs of healing, defined as a decrease in surface area and depth or a decreased amount of exudate and necrotic tissue, with comprehensive therapy including all of the following:
    - Application of dressings to maintain a moist wound environment
    - Debridement of necrotic tissue, if present
    - Offloading of weight
- A diagnosis of type 1 or type 2 diabetes ~~mellitus~~
  - An ~~glycated hemoglobin (~~HbA1c~~)~~ level of ≤ 9% within the last 90 days or a documented plan to improve HbA1c to ≤ 9% ~~9% or below~~ as soon as possible
- Evidence of adequate circulation to the affected extremity, as indicated by ~~one~~ 1 or more of the following:
  - ~~Ankle-brachial index (~~ABI~~)~~ of at least 0.7
  - Toe-brachial index (TBI) of at least 0.5
  - Dorsum transcutaneous oxygen test (TcPO2) ≥ ~~>=~~ 30 mm~~-~~Hg
- Triphasic or biphasic Doppler arterial waveforms at the ankle of the affected leg
- No evidence of untreated wound infection or underlying bone infection
  - Ulcer does not extend to tendon, muscle, joint capsule~~,~~ or bone or exhibit exposed sinus tracts unless the product indication for use allows application to such ulcers

The beneficiary must not have any of the following:

· Active Charcot deformity or major structural abnormalities of the foot, when the ulcer is on the foot
· Active and untreated autoimmune connective tissue disease
· Known or suspected malignancy of the ulcer
· Beneficiary ~~is~~ receiving radiation therapy or chemotherapy
· Re-treatment of the same ulcer within ~~one~~ 1 year

Coverage l~~L~~imitations

The following coverage limitations apply:

- Coverage is limited to a maximum of 10 treatments within a 12-week period.
- If there is no measurable decrease in surface area or depth after ~~five~~ 5 applications, then further applications are not covered.
- For all ulcers, a comprehensive treatment plan must be documented, including at least all of the following:
  - Offloading of weight
  - Smoking cessation counseling and/or medications, if applicable
  - Edema control
  - Improvement in diabetes control and nutritional status
  - Identification and treatment of other comorbidities that may affect wound healing such as ongoing monitoring for infection
- While providers may change products used for the diabetic lower extremity ulcers, simultaneous use of more than ~~one~~ 1 product for the diabetic lower extremity ulcers is not covered.
- Hyperbaric oxygen therapy is not covered when used at the same time as skin substitute treatment.

Prior a~~A~~uthorization
Skin substitutes require prior authorization, and submitted medical documentation must demonstrate that the beneficiary meets all of the aforementioned requirements.

Note~~OTE~~: If there is no measurable decrease in surface area~~,~~ or depth after ~~five~~ 5 applications, then further applications are not covered, even when pre~~ior~~ authorized.

Sterilization

Coverage r~~R~~equirements
In accordance with federal regulations, Humana Healthy Horizons ~~in Louisiana~~ covers sterilizations if the following requirements are met:
- The individual is at least 21 years of age at the time ~~the~~ consent is obtained.
- The individual is ~~not a~~ mentally ~~in~~competent. ~~individual~~
- The individual has voluntarily given informed consent in accordance with all federal requirements.
- At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since a member gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Humana Healthy Horizons ~~in Louisiana shall~~will not cover hysterectomies performed solely for the purpose of terminating reproductive capability (sterilization).

Sterilization c~~C~~onsent f~~F~~orm r~~R~~equirements
Humana Healthy Horizons ~~in Louisiana~~ directs providers to use the current sterilization consent forms (HHS-687 available in English and HHS-687-1 available in Spanish) from the U.S. Department of Health and Human Services website.

Humana Healthy Horizons ~~in Louisiana~~ requires the consent form to be signed and dated by:
- The individual to be sterilized
- The interpreter, if one was provided
- The person who obtained the consent
- The ~~physician~~ provider performing the sterilization procedure

Note~~OTE~~: If the ~~physician~~ provider who performed the sterilization procedure is the one who obtained the consent, the ~~physician~~ provider must sign both statements.

The ~~physician~~ provider who obtains the consent must share the consent form with all providers involved in that member's care (e.g., attending ~~physician~~provider, hospital, anesthesiologist~~,~~ and assistant surgeon).

Members who undergo a covered hysterectomy must complete a hysterectomy consent form but are not required to complete a sterilization consent form.

Consent f~~F~~orms and n~~N~~ame c~~C~~hanges
For services requiring a sterilization consent form, the member's name on the Medicaid file for the date of service must be the same as the name signed at the time of consent. If the member's name is different, the provider must attach a letter from the provider's office from which the consent was obtained. The letter must be signed by the ~~physician~~

provider,~~and must~~ state that the member's name has changed and ~~must~~ include the member's S~~s~~ocial S~~s~~ecurity number and date of birth.

It is Humana Healthy Horizons' ~~in Louisiana~~ responsibility to ensure ~~that~~ required documentation is maintained by the provider.

Correcting the ~~s~~Sterilization ~~c~~Consent ~~f~~Form

The informed consent must be obtained and documented prior to the ~~performance of the~~ sterilization.
Errors in the following sections can be corrected~~,~~ but only by the person over whose signature they appear:

- "Consent to Sterilization"
- "Interpreter's Statement"
- "Statement of Person Obtaining Consent"
- "Physician's Statement"

If either the member, the interpreter~~,~~ or the person obtaining consent returns to the office to make a correction to that person's respective ~~his or her~~ portion of the consent form, the medical record must reflect ~~his or her~~their the individual's presence in the office on the day of the correction.

To make an allowable correction to the form, the individual making the correction must line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction. Erasures, "write-overs"~~,~~ or use of correction fluid in making corrections are unacceptable.

Only the member can correct the date to the right of the member's~~ir~~ signature. The same applies to the interpreter~~,~~ ~~to~~ the person obtaining consent~~,~~ and ~~to~~ the ~~doctor~~provider. The corrections of the member, ~~the~~ interpreter~~,~~ and the person obtaining consent must be made before the claim is submitted.

The date of the sterilization may be corrected either before or after submission by the ~~doctor~~ provider over whose signature it appears. However, the operative report must support the corrected date.

Reimbursement

Prior to reimbursement, Humana Healthy Horizons ~~in Louisiana shall~~ will ensure that the sterilization consent form is obtained. Humana Healthy Horizons ~~in Louisiana shall~~will allow ancillary providers and hospitals to submit claims without the hard copy consent. Humana Healthy Horizons ~~in Louisiana shall~~will reimburse these providers only if the provider performing the sterilization submitted a valid sterilization consent form and was reimbursed for the procedure.

Humana Healthy Horizons ~~in Louisiana~~ is responsible for maintaining required documentation and ~~shall~~ will not shred documentation without prior approval by LDH.

Telemedicine/t~~T~~elehealth

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a ~~physician~~ provider ~~or other licensed practitioner~~ and ~~a~~ member are not in the same location.

The telecommunications system ~~shall~~ should include, at a minimum, audio and video equipment permitting two-way, real- time interactive communication between the beneficiary at the originating site and the ~~physician or other licensed practitioner~~provider at the distant site. The telecommunications system must be secure, ensure patient confidentiality~~,~~ and be compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Originating site means the location of the Medicaid member at the time the services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school~~,~~ or the member's home.

Distant site means the site at which the ~~physician or other licensed practitioner~~provider is located at the time ~~the~~ services are provided. When approved by LDH in accordance with the c~~C~~ontract, the distant site may include a provider or facility that is not physically located in this state in temporary or emergency situations (e.g., pandemics, natural disasters).

When otherwise covered, Humana Healthy Horizons ~~in Louisiana~~ covers services located in the t~~T~~elemedicine appendix of the CPT manual, or its successor, when provided by telemedicine/telehealth. In addition, Humana Healthy Horizons ~~in Louisiana~~ covers other services provided by telemedicine/telehealth when indicated as covered via telemedicine/ telehealth in Medicaid program policy. ~~The MCO shall~~Humana Healthy Horizons ~~in Louisiana~~ ensures adequate availability of telemedicine/telehealth during declared emergencies, disasters~~,~~ and pandemics. ~~Physicians and other licensed practitioners~~Providers must continue to adhere to ~~all~~ existing clinical policy for all services rendered. Providing services through telemedicine/telehealth does not remove or add any medical necessity requirements.

~~declared emergencies, disasters, and pandemics. Physicians and other licensed practitioners must continue to adhere to all existing clinical policy for all services rendered. Providing services through telemedicine/telehealth does not remove or add any medical necessity requirements.~~

Tobacco c~~C~~essation s~~S~~ervices

Humana Healthy Horizons ~~in Louisiana~~ covers tobacco cessation counseling for ~~pregnant members when provided~~all members when provided by, or under the supervision of, the member's PCP or ~~OB provider~~other appropriate healthcare provider. Tobacco cessation counseling may be provided by other appropriate healthcare professionals upon referral from the member's PCP ~~or OB provider~~, but all care must be coordinated.

~~During the prenatal period through 60 days postpartum,~~ Humana Healthy Horizons ~~in Louisiana~~ covers up to ~~four (~~4~~)~~ tobacco cessation counseling sessions per quit attempt and~~,~~ up to ~~two (~~2~~)~~ quit attempts per calendar year, for a maximum of ~~eight (~~8~~)~~ counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

Minimum reimbursement for tobacco cessation counseling ~~shall be~~is based on the applicable ~~current procedural terminology (~~CPT~~)~~ code on the Professional Services Fee Schedule and must be supported by appropriate documentation. ~~Humana Healthy Horizons in Louisiana require the -TH modifier to be included on claims for tobacco cessation counseling within the prenatal period. The -TH modifier is not to be used for services in the postpartum period.~~

If tobacco cessation counseling is provided as a significant and separately identifiable service on the same day as an E&M visit and is supported by clinical documentation, a modifier to indicate a separate service may be used, when applicable.

Urine d~~D~~rug t~~T~~esting

Humana Healthy Horizons ~~in Louisiana~~ covers presumptive and definitive urine drug testing under the following parameters:

- Presumptive drug testing is limited to 24 total tests per member per calendar year.
- Definitive drug testing is limited to 12 total tests per member per calendar year. Definitive drug testing is limited to individuals with an unexpected positive or unexpected negative finding on presumptive drug testing or if there is a clinical reason to detect a specific substance or metabolite that would be inadequately detected through presumptive drug testing.
- Testing more than 14 definitive drug classes in ~~one~~ 1 test is not reimbursable.
- No more than one presumptive test and one definitive test ~~shall~~ will be reimbursed per day, per member, from the same or a different provider.
- Universal drug testing (screening) in a primary care setting is not covered. Drug testing without signs or symptoms of substance use or without current controlled substance treatment is not covered.

~~Tivity~~

~~Plan members receive covered massage and acupuncture management services through participating providers through WholeHealth Networks, Inc., a Tivity company.~~
~~For more information, providers can call Tivity at~~
~~**888-338-5042** or visit WholeHealthPro.com.~~

Behavioral health ~~and substance -use~~ services[CC69][DB70]

Behavioral health ~~and substance -use~~ services [CG71][CC72][DB73]are covered for Humana Healthy Horizons ~~in Louisiana~~ members.

Understanding that both behavioral and physical health equally affect a person's wellness, Humana Healthy Horizons ~~in Louisiana~~ uses a holistic treatment approach to address mental ~~behavioral~~ health and substance use.

Humana Healthy Horizons ~~in Louisiana~~ provides a comprehensive range of basic and specialized behavioral health services including:

- Basic behavioral health services: Services provided through primary care including, but not limited to, screening for mental health and substance use issues, prevention, early intervention, and~~,~~ medication management as well as treatment and referral to specialty services.
- Specialized behavioral health services:
  - ~~Licensed Mental Health Professional (~~LMHP~~)~~ services provided by licensed ~~Medical~~medical psychologists, licensed psychologists, ~~licensed clinical social workers (~~LCSWs~~)~~, ~~licensed professional counselors (~~LPCs~~)~~, licensed marriage and family therapists (LMFTs~~)~~, licensed addiction counselors (LACs~~),~~ and ~~advanced practice registered nurses (~~APRNs~~)~~
- Community Psychiatric Support & Treatment (CPST) (all ages)
- Psychosocial Rehabilitation (PSR) (all ages)
- Crisis Intervention (CI) (all ages)
- Assertive Community Treatment (ACT) (age ~~22~~-18 and older)
- ~~Assertive Community Treatment (ACT) (18 to 21)~~[CC74]~~[DB75]~~[CC76]~~including but not limited to medication~~ ~~[CC77]~~[DB78][CC79][CC80][DB81][DB82]~~management, individual, family, and group counseling) (all ages)~~
- Crisis Responses Services
- a. Mobile Crisis Response (MCR) (all ages)
- b. Behavioral Health Crisis Care (BHCC) (age 21 and older)
- c. Community Brief Crisis Service (CBCS) (all ages)

- Crisis Stabilization (CS) (all ages)
- Individual Placement and Supports (IPS) (age 18 and older)
- Personal Care Services (PCS) (age 21 and older)
- Peer Support Services (PSS) (age 21 and older)
- Outpatient Therapy with Licensed Practitioners (including but not limited to medication [CC83][DB84]management, individual, family, and group counseling) (all ages)
- Addiction Services (outpatient and , residential, ~~and inpatient~~) [CC85][DB86][FB87][DB88][MG89][FB90][MMB91][DB92][MG93]
- Psychiatric Inpatient Hospital (age 18 to 21 years and over 65)
- Psychiatric Residential Treatment Facility (PRTF) (age under 21)
- Opioid Treatment Programs (OTPs) (age 18 and older)[FB94][DB95][MG96]
- Therapeutic Group Home (age under 21)
- Multi-systemic Therapy (MST) (age range 12 to 17)
- Functional Family Therapy (FFT) (age 10 to 18)
- Homebuilders (HB) (age birth to 18)
- Child Parent Psychotherapy (CPP) (ages birth to 6)
- Parent-child interaction therapy (PCIT)
- Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (age 3 to 18)
- Eye Movement Desensitization and Reprocessing (EMDR) Therapy (age 2 to adult)
- Federally Qualified Health Center (FQHC)
    - ~~Outpatient treatment~~
    - ~~Parent-child interaction therapy (PCIT)~~
    - ~~Child parent psychotherapy (CPP)~~
    - ~~Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)~~
    - ~~Triple P Positive Parenting Program~~
    - ~~Trauma-focused cognitive behavioral therapy~~
    - ~~Eye movement desensitization and reprocessing (EMDR) therapy~~
    - ~~Mental health rehabilitation services~~
        - ~~Community Psychiatric Support and Treatment (CPST)~~
        - ~~Multi-systemic therapy (MST) (target age 12-17)~~
        - ~~Functional family therapy (FFT) (target age 10-18) and functional family therapy-child Welfare (target age 0-18)~~

- Homebuilders® (target age 0-18)
- Assertive community treatment (target age 18 and older)[AD97][DB98]
- Psychosocial rehabilitation (PSR)
- Crisis Response Services Crisis intervention
  - Crisis stabilization[AD99][DB100][AD101][DB102]
- [AD103][DB104]Therapeutic group homes (TGH) (age 0-20)
- Psychiatric residential treatment facilities (PRTF) (age 0-20)
- Inpatient hospitalization
- Outpatient and residential substance use disorder services
- Medication assisted treatment
- Opioid Treatment Program
- Behavioral Health Services in Federally Qualified Health Centers and Rural Health Centers
- Mobile cCrisis rResponse
- Behavioral hHealth cCrisis cCare (age 21 and older)
- Community Brief Crisis Support (CBCS)[AD105][DB106]
- Individual Placement and Support (IPS) (ages 21 and older)[AD107][DB108]
- Peer Support Services (ages 21 and older)
- Personal cCare sServices (ages 21 and older)

Humana Healthy Horizons' in Louisiana's network focuses on improving member health through evidence-based practices. The Our goal: We wantis to provide the level of care needed by the member within the safest least restrictive setting.[FB109][DB110]

Screening and evaluation

Humana Healthy Horizons in Louisiana requires network PCPs to receive the following training:

- Screening and evaluation procedures for identification and treatment of suspected behavioral health problems and disorders
- Application of clinically appropriate behavioral health services, screening techniques, clinical coordination, and quality of care within the scope of their practices

Care management and care coordination

Humana Healthy Horizons in Louisiana cCare mManagers are available to promote a holistic approach to addressing a member's physical and behavioral healthcare needs as well as social determinant issues. Humana Healthy Horizons in Louisiana also offers chronic condition management programs for behavioral mental health and substance use, as well as care management programs based upon a member's level of need (see Chapter 12:10 XII Care mManagement programst Programs in this manual). Call 1-**800-448-3810 (TTY: 711)** to refer members needing care management assistance. If you prefer, email LAMCDCaseManagement@hHumana.com.

Humana Healthy Horizons in Louisiana adheres to a no-wrong-door approach to care management referrals. Humana Healthy Horizons in Louisiana will assist with provider referrals, appointment scheduling and coordination of an integrated approach to the member's health and well-being by coordinating care between among behavioral health providers, PCPs, and specialists. Behavioral health providers are required to send initial and quarterly summary reports to the member's PCP, and to refer members to their PCP for untreated physical health concerns.

For further information about our integrated care management programs, please refer to Chapter 3: Provider Services section of this manual.

Continuation of treatment

Humana Healthy Horizons in Louisiana requires that an outpatient follow-up appointment be scheduled prior to a member's discharge from an in-patient behavioral health treatment facility. The appointment must occur within seven 7 days of the discharge date. Behavioral healthcare providers are expected to contact patients within 24 hours of a missed appointment to reschedule.

Emergency and non-emergency medical transportation (NEMT)

For emergency transportation services, call 911.

If a member requires non-emergency transportation to a healthcare appointment or pharmacy immediately following a doctor visit, he or shethe member may call MediTrans at 1-**844-613-1638**. Humana Healthy Horizons in Louisiana will

make every effort to schedule urgent transportation requests as soon as they are needed, but the member should call at least 48 hours before the appointment time.

~~Non-emergency Medical Transportation~~NEMT and ~~n~~Non-emergency ~~a~~Ambulance ~~t~~Transportation providers ~~shall~~ will pick up members no later than ~~three~~ 3 hours after notification by an inpatient facility of a scheduled discharge or ~~two~~ 2 hours after the scheduled discharge time, whichever is later.

Excluded services

Humana Healthy Horizons ~~of Louisiana~~ must provide covered services under current administrative regulations. The scope of services may be expanded with LDH approval and as necessary for compliance with federal and state laws. Certain Medicaid services are excluded from Humana Healthy Horizons'~~s~~ benefits package but are covered through the traditional fee-for-service Medicaid program. Humana Healthy Horizons ~~in Louisiana~~ is expected to be familiar with these excluded services and designated Medicaid wrap-around services~~,~~ and coordinate service delivery with LDH providers.

Information relating to these excluded service programs may be accessed by Humana Healthy Horizons ~~of Louisiana~~ from LDH to help coordinate services.

Under federal law, Medicaid does not receive federal matching funds for certain services. Some of these are optional services that ~~the~~ LDH may elect to cover. Humana Healthy Horizons is not required to cover services that Louisiana Medicaid has elected not to cover.

The following excluded services are available to members under the state plan or applicable waivers and are not provided through Humana Healthy Horizons ~~in Louisiana~~:~~.~~

- Adult dental services with the exception of surgical dental services and emergency dental services
  - ~~.~~For additional adult dental services offered by Humana Healthy Horizons, ~~in Louisiana~~ see Chapter 14~~XIV~~: Value-added b~~B~~enefits.
- Services to individuals in i~~I~~ntermediate c~~C~~are f~~F~~acilit~~ies~~ for i~~I~~ndividuals with d~~D~~evelopmental d~~D~~isabilities (ICFs/IDDs)~~.~~
- Nursing facility services, with the exception of post-acute rehabilitative care, provided at the discretion of the contractor when it is cost effective to do so in place of continued inpatient care as an in lieu of service~~.~~
- Individualized e~~E~~ducation p~~P~~lan (IEP) services, including physical ~~therapy~~, occupational ~~therapy,~~ and speech-~~/~~language therapy, audiology~~,~~ and some psychological therapy, provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by Office of Public Health [OPH]-certified, school-based health clinics)~~.~~
- All home- and community-based waiver services~~.~~
- Targeted case management services~~.~~
- Services provided through LDH's EarlySteps p~~P~~rogram (Individuals with Disabilities Education Act [~~(~~IDEA]~~)~~, Part C p~~P~~rogram s~~S~~ervices)~~.~~

The following are excluded drugs:

- Select agents when used for symptomatic relief of cough and colds, not including prescription antihistamine and antihistamine/decongestant combination products
- Select agents when used for anorexia, weight loss or weight gain, not including orlistat
- Select agents when used to promote fertility, not including vaginal progesterone when used for high-risk pregnancy to prevent premature births
- Drug Efficacy Study Implementation (DESI) drugs
- Select nonprescription drugs, not including over-the-counter (OTC) antihistamines, antihistamine/decongestant combinations~~,~~ or polyethylene glycol
- Narcotics other than those indicated for substance use disorder when treating ~~narcotic addiction~~[MMB111][DB112][TM113][DB114]opioid use disorder~~.~~

The following prohibited services are not Medicaid-covered services and ~~shall~~ will not be provided to members:

- Any service (drug, device, procedure~~,~~ or equipment) that is not medically necessary
- Experimental/investigational drugs, devices, procedures~~,~~ or equipment, unless approved by the LDH s~~S~~ecretary ~~of LDH~~
- Cosmetic drugs, devices, procedures or equipment
- Assistive reproductive technology for treatment of infertility
- Elective abortions (those not covered in the Louisiana Medicaid s~~S~~tate p~~P~~lan) and related services
- Surgical procedures discontinued before completion
- Harvesting of organs when a Louisiana Medicaid member is the donor of an organ to a non-Medicaid member
- Provider preventable conditions (PPCs) as below:
  - PPCs are defined in~~to~~ ~~two~~2 categories:

- Health-care-acquired condition (HCAC), meaning a condition occurring in any inpatient hospital setting, identified as a hospital--acquired condition (HAC) in accordance with 42 C.F.R. § 447.26; and
- Other provider preventable condition (OPPC), meaning a condition occurring in any health-care setting in accordance with 42 C.F.R. § 447.26.

Out-of-network care when services are unavailable

Humana Healthy Horizons in Louisiana will arrange for out-of-network care if it is unable to provide necessary covered services or, a second opinion,, or if a network healthcare provider is unavailable. Humana Healthy Horizons in Louisiana

~~will coordinate payment with the out-of-network provider to confirm that any cost to the member is not greater than it would be if the service were provided in-network.~~

All ~~O~~out-of-network and out-of-state provider services require prior authorization unless services are required to treat an emergency medical condition. [CC115][DB116]

Sterilization

~~In order f~~For a claim to be considered for payment, Humana Healthy Horizons requires the following forms to be submitted with the claim:

- For a sterilization procedure, ~~—~~Form OMB No. 0937-0166, ~~"~~Consent to Sterilization
  - ~~"~~ Ancillary and hospital providers are not required to submit a hard copy of the form and can only be reimbursed if the provider performing sterilization submitted a valid ~~"~~Consent to Sterilization~~"~~ form and was reimbursed.
- For a hysterectomy, ~~—~~Form 96-A, ~~"~~Acknowledgement of Receipt of Hysterectomy Information
  - ~~"~~The ~~"~~Consent to Sterilization~~"~~ form is not required for a hysterectomy.

Chapter 5~~HAPTER V~~: Utilization ~~TILIZATION~~ Management~~ANAGEMENT (UM)~~

Utilization M~~m~~anagement helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons ~~in Louisiana~~ members. Utilization review determinations are based on medical necessity, appropriateness of care and service and existence of coverage. Humana Healthy Horizons ~~in Louisiana~~ does not reward providers or our staff for denying coverage or services. There are no financial incentives for Humana Healthy Horizons' ~~in Louisiana~~ staff to encourage decisions that result in underutilization. Humana Healthy Horizons ~~in Louisiana~~ does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. Humana Healthy Horizons ~~in Louisiana~~ establishes measures designed to maintain quality of services and control costs that are consistent with our responsibility to our members. We place appropriate limits on a service on the basis of criteria applied under the Medicaid state plan~~,~~ and applicable regulations, such as medical necessity. Humana Healthy Horizons ~~in Louisiana~~ places appropriate limits on a service for utilization control, provided the service furnished can reasonably be expected to achieve its purpose. Services supporting individuals with ongoing or chronic conditions or who require long-~~-~~term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports.

The ~~UM d~~Utilization Management department performs all ~~UM a~~Utilization Management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the Humana Healthy Horizons Care Management team are made, if needed.

Humana Healthy Horizons ~~in Louisiana~~ completes an assessment of satisfaction with the Utilization Management ~~UM~~ process on an annual basis, identifying areas for improvement ~~opportunities~~.

~~opportunities.~~

Criteria

Humana Healthy Horizons ~~in Louisiana~~ currently uses Milliman ~~Coverage~~ Care Guidelines (MCG) and the American Society of Addiction Medicine (ASAM), nationally recognized, evidence-based clinical Utilization Management ~~UM~~ criteria, as well as Humana Healthy Horizons clinical policies, to make medical necessity determinations of inpatient acute, behavioral health, rehabilitation~~,~~ and skilled nursing facility admissions. These guidelines are intended to allow ~~the~~ Humana Healthy Horizons ~~in Louisiana~~ to provide all members with care that is consistent with national quality standards and evidence-based guidelines. These guidelines are not intended as a replacement for medical care; they are to provide guidance to our ~~physician~~ providers related to medically appropriate care and treatment.

You can access these clinical coverage policies on Clinical coverage policies. Providers also may ~~also~~ request prior authorization review criteria used to make a medical necessity determination by sending an email to~~:~~ LAMCDCriteriaRequest@humana.com. Prior authorization requirements will be furnished to the requesting provider within 24 hours of request.

Humana Healthy Horizons ~~in Louisiana~~ will not deny continuation of higher ~~-~~level services such as inpatient hospital care for failure to meet medical necessity unless Humana Healthy Horizons ~~in Louisiana the Plan~~ is able to provide the service through an in-~~-~~network or out-of- network provider at a lower level of care.

Notice of adverse benefit determination letters include instructions on how to request ~~all~~ the criteria used in making decisions.

The guidelines ~~from MCG and ASAM~~ used to make medical necessity determinations can be requested by sending an email to~~:~~ LAMCDCriteriaRequest@humana.com.

Humana Healthy Horizons ~~in Louisiana~~ defaults to all applicable state and federal guidelines regarding criteria for

authorization of covered services. Humana Healthy Horizons ~~in Louisiana~~ also has medical coverage policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria for approval, the case is forwarded to Humana Healthy Horizons' ~~in Louisiana's~~ m~~M~~edical d~~D~~irector for further review and determination.

~~and determination.~~

Access to staff

Providers can email the ~~UM s~~Utilization Management staff with any Utilization Management ~~UM~~ questions.

- Medical health inquires: ~~-~~LAMCDMedicalUM@humana.com
- Behavioral health inquiries: ~~-~~LAMCDBehavioralHealthUM@humana.com

Please keep the following in mind when contacting Utilization Management ~~UM~~ staff:

- Staff members are ~~is~~ available ~~Monday through Friday, 7 a.m. to 5 p.m., Central time. 7days a week/~~24 hours ~~per~~a day, 7 days a week.
- Staff members can receive inbound communication regarding Utilization Management ~~UM~~ issues after normal business hours.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding Utilization Management ~~UM~~ issues.
- Staff members are available to respond to email inquiries regarding Utilization Management ~~UM~~ issues.
- Staff members are accessible to answer questions about the Utilization Management ~~UM~~ process.
- In the best interest of our members and to promote positive healthcare outcomes, Humana Healthy Horizons ~~in Louisiana~~ supports and encourages continuity of care and coordination of care between medical providers as well as between behavioral health providers.

Member health is always our top priority. Physician reviewers from Humana Healthy Horizons in Louisiana are available upon request to discuss individual cases with attending physicians.

If you would like to request a peer-to-peer discussion on an adverse determination with a Humana Healthy Horizons ~~in Louisiana physician~~provider reviewer, the~~at~~ request needs to be made within ~~five (~~5~~)~~ calendar days from the adverse determination date. ~~In order t~~To request a peer-to-peer discussion, please send an email to LAMCDP2PRequest@humana.com ~~the appropriate email address above~~ or call ~~**the telephone number listed above within five business days of the determination.**~~**1-800-448-3810 (TTY: 711)**.

Referrals

Humana Healthy Horizons ~~in Louisiana~~ members can see any participating network provider, including specialists and inpatient hospitals. Humana Healthy Horizons ~~in Louisiana~~ does not require referrals from PCPs to see participating specialists. Members may self-refer to any participating provider. PCPs do not need to arrange or approve these services for members, as long as applicable benefit limits have not been exhausted.

Second opinions for nonparticipating providers

A second opinion is not required for surgery or other medical services. However, providers or members may request a second opinion at no cost. The following criteria should be used when selecting a provider for a second opinion:
The provider:

- Must participate in the Humana Healthy Horizons ~~in Louisiana~~ Medicaid network
  - ~~.~~If not, prior authorization must be obtained.
- Must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained~~.~~
- Must be in an appropriate specialty area~~.~~
- Must be enrolled in Louisiana Medicaid through the p~~P~~rovider e~~E~~nrollment p~~P~~ortal.
  - ~~at https://www.lamedicaid.com/provweb1/default.htm.~~ If enrollment cannot be validated or ~~it~~ is incomplete, providers risk not being paid.
  - Providers ~~that are~~ unsure of their enrollment status or who ~~that~~ want to check their status ~~of providers~~ may use the p~~P~~rovider p~~P~~ortal e~~E~~nrollment l~~L~~ookup t~~T~~ool. ~~https://www.lamedicaid.com/portalenrollmentstatus/search.~~
  - Results will show the provider's status as either enrollment complete, action required, application not submitted~~,~~ or currently in process. Providers ~~that are~~ not shown in the results are not required to enroll at this time. Invitation letters for those providers will be sent at a later date. The l~~L~~ookup t~~T~~ool is updated daily.
  - Providers needing assistance with application and enrollment should contact Gainwell Technologies by emailing

LouisianaProvEnroll@gainwelltechnologies.com or ~~contacting~~calling **1-833-~~-~~641-2140** for a status update on enrollment and any next steps needed to complete the process.

Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Release due to ethical reasons

Providers are not required to perform any treatment or procedure contrary to ~~his or her~~their conscience, religious beliefs or ethical principles, in accordance with 45 C~~.~~F~~.~~R 88.

Prior authorizations

It is important to request prior authorization as soon as it is known that a service is needed.

Member eligibility is verified when a prior authorization is given for a service that will be rendered during the same month as the request. If the service will be rendered during a subsequent month, prior authorization will be given only if the treating provider is able to verify member eligibility on the date of service. Humana Healthy Horizons is not able to pay claims for services provided to ineligible members.

All services that require prior authorization from Humana Healthy Horizons ~~in Louisiana~~ should be authorized before the service is delivered. Humana Healthy Horizons ~~in Louisiana~~ is not able to pay claims for services for which prior authorization was required but not obtained by the provider. Humana Healthy Horizons will notify you of prior authorization determinations via a letter mailed to your address on file.

Concurrent/~~I~~inpatient a~~A~~uthorizations

Humana Healthy Horizons ~~in Louisiana The Plan~~ requires the provider to submit notification to Humana Healthy Horizons ~~in Louisiana the Plan~~ of all inpatient admissions within ~~one (~~1~~)~~ business day of the date of admission. Humana Healthy Horizons ~~in Louisiana The Plan~~ also requires the provider to submit notification to Humana Healthy Horizons ~~in Louisiana the Plan~~ of obstetrical admissions that exceed ~~forty-eight (~~48~~)~~ hours following a vaginal delivery or ~~ninety-six (~~96~~)~~ hours following a c~~a~~esarean section delivery.

Common o~~O~~bservation p~~P~~olicy

Humana Healthy Horizons ~~in Louisiana The Plan~~ will reimburse up to 48 hours of medically necessary care for the member to be in an observational status. Observation and ancillary services do not require notification, precertification or authorization and will be covered up to 48 hours. If a member is anticipated to be in observation status beyond 48 hours, the hospital must notify Humana Healthy Horizons ~~in Louisiana the plan~~ for potential authorization of an extension of hours.

Hospitals should bill the entire outpatient encounter, including emergency department, observation~~,~~ and any associated services, on the same claim with the appropriate revenue codes, and all covered services will be processed and paid separately.

Members should not be automatically converted to inpatient status at the end of the initial 48-hour period. If the member converts to an inpatient status, notification to Humana Healthy Horizons ~~in Louisiana the plan~~ is required within ~~one (~~1~~)~~ business day of the order to admit the member.

Observation hours will not be included in the inpatient admission notification period. Length of stay alone will not be the determining factor for a decision to deny an inpatient stay or downgrad~~e~~ing to observation stay.

Humana Healthy Horizons ~~in Louisiana The plan~~ will work with providers to coordinate the provision of additional medical services prior to discharge of the member as needed.

Prior authorization time frames

Humana Healthy Horizons ~~in Louisiana~~ will make determinations for:

- Standard outpatient service prior authorization requests within ~~two (~~2~~)~~ business days of obtaining appropriate medical information not to exceed 14 calendar days of receipt of request for prior authorization.
- ~~80% of standard service authorization determinations within two business days of obtaining appropriate medical information that may be required regarding a proposed procedure, or service requiring a review determination, with the following exceptions:~~
- Standard ~~All~~ inpatient hospital service prior authorization requests ~~authorizations~~ within ~~two (~~2~~)~~ calendar days of obtaining appropriate medical information.
- Concurrent inpatient authorization requests within ~~one (~~1~~)~~ calendar day of obtaining ~~the~~ appropriate medical information ~~that may be required.~~
- ~~All concurrent review determinations within one calendar day of obtaining the appropriate medical information that may be required.~~
- ~~All~~ Standard ~~Provider of Community Psychiatric~~Psychiatric ~~Support and Treatment (~~CPST~~),~~ ~~Functional Family Therapy (~~FFT~~),~~ ~~Assertive Community Treatment (~~ACT~~),~~ ~~Flexible Assertive Community Treatment (FACT)h~~[KC117][DB118][AD119][CC120][DB121]~~, H~~Homebuilders, ~~Multi-Systemic Therapy (~~MST~~),~~ and ~~Psychosocial Rehabilitation (~~PSR~~)~~ ~~service authorizations~~authorization requests within ~~five (~~5~~)~~ calendar days of obtaining appropriate medical information.~~[CG122][DB123]~~
- Crisis r~~R~~esponse s~~S~~ervice authorization requests within ~~one (~~1~~)~~ calendar day of obtaining ~~the~~ appropriate medical information.~~
- Expedited authorization requests within 72 hours of receipt of the request for authorization.~~
- Retrospective review requests within 30 calendar days of receipt of medical information, not to exceed 180

calendar days of receipt of request for authorization.

- All standard service authorization determinations shall will be made no later than 14 calendar days following receipt of the request for service:.
  - The service authorization determination may be extended up to an additional 14 additional calendar days if:

  - The service authorization determination may be extended up to an additional 14 calendar days if Tthe member, or the provider, requests the extension or ; or
  - Humana Healthy Horizons in Louisiana justifies (to LDH upon request) a need for additional information and how the extension is in the member's best interest.

All concurrent review determinations within one calendar day of obtaining the appropriate medical information that may be required.

Expedited service authorizations

If a provider indicates, or the MCOHumana Healthy Horizons in Louisiana determines that, following the standard service authorization time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCOHumana Healthy Horizons in Louisiana will make an expedited authorization determination and provide notice as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request for service.

Humana Healthy Horizons in Louisiana may extend the 72-hour time period by up to 14 calendar days if the member requests the extension or if the MCOHumana Healthy Horizons in Louisiana justifies to the LDH a need for additional information and how the extension is in the member's best interest.

Post-authorization

Humana Healthy Horizons in Louisiana will make retrospective review determinations within 30 calendar days of obtaining the results of any appropriate medical information that may be required, but in no instance later than 180 calendar days from the date of receipt of request for sService aAuthorization.

Humana Healthy Horizons ~~in Louisiana~~ will not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance ~~up~~on previous service authorization approval~~,~~ unless the approval was based ~~up~~on a material omission or misrepresentation about the member's health condition made by the provider.

Humana Healthy Horizons ~~in Louisiana~~ will not use a policy with an effective date after the original service authorization request date to rescind its prior authorization.

Medicaid services requiring prior authorization

The following are ~~some~~ examples of services that are provided as benefits to the member but ~~do~~ require prior authorization~~:~~.

- All medical and behavioral health inpatient care
- Food supplements/nutritional supplements
- Genetic testing
- ~~.~~ Home care services and therapies including private-duty nursing
- ~~Hospice services (inpatient, continuous care, respite care and routine home hospice care)~~
- Inpatient rehabilitative services
- Long~~-~~term acute care ~~Term Acute Care (LTAC)~~
- Organ/tissue/bone transplants
- Select durable medical equipment, regardless of amount, specifically:
  - All powered or customized wheelchairs
  - W~~w~~heelchair rentals longer than ~~three~~ 3 months
  - All miscellaneous codes (e.g., E1399)
  - Hearing aids
- Non~~-~~covered service and/or services beyond benefit limits for members younger than 21 that are deemed medically necessary or fall within the scope of EPSDT services

The prior authorization list is at Humana.com/PAL.

Note: The above website link routes to Humana Healthy Horizons'~~ in Louisiana's~~ comprehensive preauthorization and notification lists for multiple Humana plans. The ~~plans. The~~ term "preauthorization," also known as prior authorization, precertification and preadmission, is a process through which the ~~physician or other~~ healthcare provider is required to obtain advance approval from Humana Healthy Horizons ~~in Louisiana the plan~~ as to whether the item or service will be covered.

Services that do not require prior authorization

Some services **do not** ~~DO NOT~~ require authorization by Humana Healthy Horizons. T~~ in Louisiana. T~~hese services include but are not limited to:

- Emergency and~~&~~ p~~P~~ost-s~~S~~tabilization s~~S~~ervices
- Non~~e~~-~~E~~mergent newborn deliveries
- Continuation of medically necessary services for members transitioning from other MCO~~'~~s
- Crisis s~~S~~tabilization
- EPSDT s~~S~~creening and other appropriate immunizations/vaccinations based on the Periodicity Schedule~~s~~
  - EPSDT p~~P~~reventative s~~S~~creening based on the American Academy of Pediatrics (AAP)/Bright Futures "Recommendations for Preventive Pediatric Health Care" schedule
  - Immunizations/vaccinations based on "Child and Adolescent Immunization Schedule" recommended by ACIP~~Advisory Committee on Immunization Practices~~, AAP~~,~~ and the American Academy of Family Physicians
- Dialysis
- All p~~P~~reventive s~~S~~ervices for c~~C~~ommunicable d~~D~~iseases and f~~F~~amily p~~P~~lanning s~~S~~ervices

Requesting prior authorization

This section describes how to request prior authorization for medical and radiology services.

For pharmacy prior authorization information, refer to the p~~P~~harmacy section of this manual.

Medical and~~&~~ b~~B~~ehavioral h~~H~~ealth s~~S~~ervices

Prior authorization for healthcare services can be obtained by contacting the Utilization Management ~~UM~~ department online or~~,~~ via email, fax or phone.

~~Visit the provider portal at Availity Essentials.com.~~

- Visit the provider portal at Availity Essentials.
- Access various prior authorization forms online at Humana.com/providers.

- Email completed forms to CorporateMedicaidCIT@humana.com.
- Fax completed prior authorization forms to 1-833-974-0059.
- Call **1-800-448-3810 (TTY: 711)** and follow the menu prompts for authorization requests, depending on your need.
- Mail completed prior authorization forms to:
  Humana, Inc.
  P.O. Box 14822
  Lexington, KY 40512-4822

When requesting authorization, please provide the following information:

- Member/patient name and Humana Healthy Horizons ID number
- Provider name
- National Provider Identifier (NPI) and tax ID number (TIN) for ordering/servicing providers and facilities
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to a non-participating provider, if applicable
- Clinical information to support the medical necessity of the service
- If in-patient admission for elective, urgent or emergency care is being requested, please include aAdmitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs for in-patient admission for elective, urgent or emergency care.
- If inpatient surgery is planned, please include the dateDate of surgery, name of surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs for inpatient planned surgery.
- If outpatient surgery is being requested, please include the dateDate of surgery, name of surgeon and facility, diagnosis, procedure planned, and anticipated follow-up needs after discharge. for outpatient surgery

Authorization is not a guarantee of payment. Authorization is based on medical necessity and is contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Administrative denials may be rendered when applicable authorization procedures are not followed. Members cannot be billed for services that are administratively denied due to a provider not following the requirements listed in this manual.

Prior authorization for specific oncology services

Effective 10.1.22, New Century Health (NCH) will review prior authorization requests for Humana Healthy Horizons (Louisiana) members with a cancer or hematology diagnosis.

The following will require a prior authorization from NCH before administration of the drug or treatment in the provider's office, outpatient hospital, ambulatory setting or infusion center: oncology-related infused (oral when part of an infused regimen) chemotherapeutic drugs; hematology-related drugs; symptom management medications and supportive agents. Medical specialties that will submit requests to NCH include gynecologic oncology, hematology, medical oncology, and urology.

Please submit all requests for chemotherapy, hormonal therapeutic treatment, symptom management medications, and supportive agents for your patients with Humana Healthy Horizons (Louisiana) coverage to NCH.

Choose from the following options to submit a prior authorization request:

- Log into New Century Health's provider portal at: my.newcenturyhealth.com
- If you do not have a username and password, you may complete the online registration at my.newcenturyhealth.com, and click REGISTER NOW.
- If you are unable to complete the online registration or need assistance, please direct your registration request to Network Operations at **888-999-7713** option, 6. Or, send an email to providertraining@newcenturyhealth.com.

~~· Contact New Century Health's Utilization Management Intake Department at **888-999-7713**, option 1 for medical oncology Monday through Friday (7 a.m. to~~

~~7 p.m. EST)~~

Retrospective review

Prior authorization is required to ensure ~~that~~ certain services provided to our members are medically necessary and appropriately provided. At the provider's request, Humana Healthy Horizons ~~in Louisiana~~ will conduct~~s~~ a retrospective review~~s~~ to determine whether an authorization will be granted for services rendered ~~before a~~ prior to an authorization ~~for the services was~~being requested. ~~If you fail to obtain prior authorization before services are rendered, you have 90 days from the date of service OR inpatient discharge date, OR receipt of the primary insurance carrier's explanation of payment (EOP) to request a retrospective review of medical necessity. Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal.~~

A request for retrospective review can be made by calling **1-800-448-3810 (TTY: 711)** and following the appropriate menu prompts. You also can ~~also~~ fax the request to **1-833-974-0059**. Clinical information supporting the service must accompany the request.

Continuity of care

Members with special healthcare needs

If, at the time of enrollment, a new member is actively receiving medically necessary covered services from the previous MCO, Humana Healthy Horizons ~~in Louisiana~~ will provide continuation/coordination of such services for up to 90 calendar days or until the member may be reasonably transferred without disruption, whichever is ~~first~~less. Humana Healthy Horizons ~~in Louisiana~~ may require prior authorization for continuation of the services beyond 30 calendar days; however, under these circumstances, authorization will not be denied solely on the basis that the provider is a non-participating provider.

Pregnant women

When a pregnant new member is receiving covered, medically necessary services from ~~the~~ a previous MCO in addition to, or other than, prenatal services, Humana Healthy Horizons ~~in Louisiana~~ will temporarily cover the costs of continuation of such medically necessary services. After 30 days, Humana Healthy Horizons ~~in Louisiana~~ may require prior authorization for continuation of services, but authorization will not be denied at that point solely because of a provider's contract status. Humana Healthy Horizons ~~in Louisiana~~ may continue services uninterrupted for up to 90 calendar days or until the member may be reasonably transferred without disruption, whichever is less.

During the first trimester, Humana Healthy Horizons ~~in Louisiana~~ will cover the costs of continued medically necessary prenatal care, delivery and post-natal care services without any form of prior authorization and regardless of the provider's contract status until Humana Healthy Horizons ~~in Louisiana~~ can safely transfer the member to a network provider without impeding service delivery.

During the second and third trimesters, Humana Healthy Horizons ~~in Louisiana~~ will cover the costs of continued access to the prenatal care provider (whether contract or non-contract provider) for 365 calendar days post-partum, provided the member remains covered through Humana Healthy Horizons ~~in Louisiana~~, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period.

If you have additional questions regarding Humana

Healthy Horizons' ~~in Louisiana's~~ continuity of care process and authorizations for new members, please call us at

1-800-448-3810 (TTY: 711).

Louisiana Medicaid Electronic Health Record (~~EHR~~EHR) Incentive Payment Program

This program provides incentive payments to eligible professionals ~~(EPs)~~, eligible hospitals ~~(EHs)~~ and critical access hospitals ~~(CAHs)~~ ~~who~~ that have adopted (acquired and installed), implemented (trained staff, deployed tools, exchanged data)~~,~~ and/or upgraded (expanded functionality or interoperability) ~~or~~ (AIU)~~,~~ ~~certified~~ certified EHR technology for first-year~~Year 1~~ AIU participation and attest to its corresponding meaningful use ~~(MU)~~ requirements and deadlines as outlined by CMS and the Office of the National Coordinator for Health Information Technology ~~(ONC)~~ for up to ~~five~~ 5 remaining participation years.

The purpose of the program is to improve outcomes, facilitate access, simplify care and reduce healthcare costs ~~of health care~~ nationwide by e~~:~~

- ~~E~~nhancing care coordination and patient safety; reducing paperwork and improving efficiencies; facilitating information sharing across providers, payers~~,~~ and state lines; and enabling communication of health information to

authorized users through state ~~Health Information Exchanges (~~HIEs~~)~~ and the Nationwide~~al~~ Health Information Network ~~(NHIN)~~.

- Details about this program and registration instructions can be found at Louisiana Medicaid EHR Incentive Payment Program.~~:~~ ~~https://www.lamedicaid.com/provweb1/ EHR/EHRIndex.htm.~~

Additional emergency department HIE requirements

Network emergency departments are required to exchange ~~admi~~admission, ~~t~~ discharge and transfer (ADT) data with an ~~Health~~

~~Information Exchange (~~HIE~~)~~ emergency department visit registry to aid in identification ~~of~~ and creation of policies around high utilizers, drug~~-~~-seeking behavior~~,~~ and c~~C~~are m~~M~~anagement. The visit registry ~~shall~~ must consist of ~~three~~ 3 basic attributes:

~~1.~~• The ability to capture and match patients based on demographics information~~,~~
~~2.~~• The ability to identify the facility at which care is being sought~~, and~~
~~3.~~• At minimum, the chief complaint of the visit~~.~~

These ~~three~~ 3 pieces of information are commonly available through the Health Level Seven (HL7) ADT message standard and in use by most emergency department ~~ED~~ admission systems in use ~~today~~ across the country. This data ~~shall~~ must be available in real time to assist providers and systems with up-to-date information for treating patients appropriately.

Chapter~~HAPTER~~ 6~~VI~~: Claims and encounter submission, protocols and standards ~~LAIMS AND ENCOUNTER SUBMISSION PROTOCOLS AND STANDARDS~~

Medical claims and behavioral health encounters

Healthcare providers ~~shall~~ should submit claims for all covered services for Humana Healthy Horizons ~~in Louisiana~~ members to Humana.

Paper claims should be submitted to the address listed on the back of the member's ID card or to the appropriate address listed below:

Medical claims and behavioral health encounters:
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

When filing an electronic claim, use one of the following payer IDs:
- 61101 for fee-for-service claims
- 61102 for encounter claims

Here are commonly used claims clearinghouses and their phone numbers:

Availity Essentials®	1-800-282-4548
Ways~~S~~tar	1-877-494-7633
Trizetto	1-800-969-3666
Change Healthcare ~~(formerly Emdeon)~~	1-800-792-5256
SSI Group	1-800-880-3032

Paper claims should be submitted to the address listed on the back of the member's ID card or to the appropriate address listed below:

Medical claims and behavioral health encounters:
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

LDH requires that all service encounters be submitted, including:
- Services paid at $0
- Fee-for-service and capitated provider encounters that require provider registration and documentation

Submission of provider service claims that identify members:
- Decreases the need to request medical records for review
- Decreases the appearance of member cost in reports
- Is critical to Medicaid risk adjustment effectiveness
- Helps identify members receiving preventive screenings

Sanctions for noncompliance can include liquidated damages and enrollment freezes.

Humana Healthy Horizons ~~in Louisiana~~ will issue payments for covered services provided to Medicaid members within 30 calendar days (or less,

provided all required claim documentation is submitted and the contracted parties agree to another time frame that's in accordance with payment rates outlined in Exhibit A of the provider agreement).

Humana Healthy Horizons ~~in Louisiana physician~~provider claim~~s~~ payments include an itemized accounting of individual payment claims featuring the member's name, ~~the~~ date(s) of service, procedure code(s), service units, reimbursement amounts and identification of the Humana entity.

Note~~OTE~~: Humana Healthy Horizons ~~in Louisiana~~ does not pay ~~—~~ directly or indirectly ~~—~~ a ~~physician~~ provider as an inducement to reduce or limit medically necessary services to members. Humana Healthy Horizons also doesn't provide incentives, monetary or otherwise, for the withholding of medically necessary care.

For claim payment inquiries or complaints, please contact Humana Healthy Horizons C~~in Louisiana c~~ustomer ~~service~~ Care at **1~~-~~800~~-~~448~~-~~3810 (TTY: 711) ~~800-448-6262 (800-4HUMANA)~~** or your provider contracting representative. You also may visit Availity Essentials~~.com~~ to review claim status and details. Submit claim disputes to:
Humana Inc.
P.O. Box 14601
Lexington, KY 40512 4601

If there is a factual disagreement with a response, send an email with the reference number to LAMedicaidProviderRelations@humana.com.

Common submission errors and how to avoid them

Humana Healthy Horizons ~~in Louisiana~~ may reject claims because of missing or incomplete information. Common rejection or denial reasons follow:

- Patient not found
- Insured subscriber not found
- Patient ~~birth~~date of birth on the claim does not match that found in our database
- Missing or incorrect information
  - Incorrect ~~National Provider Identifier (~~NPI~~)~~/ZIP code/taxonomy
  - Missing NPI/ZIP code/taxonomy
  - Encounters with $0 value
- Invalid ~~Healthcare Common Procedure Coding System (~~HCPCS~~)~~ code
- No authorization found

How to avoid these errors:

- Confirm that patient information received and submitted is accurate and correct
- Ensure that all required claim form fields are complete and accurate
- Obtain proper authorizations for rendered services
- Confirm provider information (information registered with LDH)
- Ensure billed amounts have a dollar value

If a claim is received~~,~~ but additional information is required for adjudication, the claim may pend and a request in writing for the necessary information will be sent.

Currently, Provider Enrollment Compliance Implementation (PECI) e~~E~~dits 314 and 641 are set to educational and were scheduled to begin ~~denying~~denials on Nov.~~ember~~ 11, 2023. To allow for increased provider transparency and time to comply with provider enrollment rules, these educational edits are extended and will now end on Dec.~~ember~~ 31, 2023. Denials for e~~E~~dits 314 and 641 will begin ~~denying~~ on Jan.~~uary~~ 1, 2024.~~-~~

Clean claim~~s~~ submission

~~The Centers for Medicare & Medicaid Services (~~CMS~~)~~ developed claim forms that record the information needed to process and generate provider reimbursement. A clean claim is complete, legible, accurate, ~~and~~ does not require investigation prior to adjudication and can be processed without additional provider information.

Clean claim submission involves providing the required data elements on standard claims forms along with any attachments and additional information. Inpatient and facility claims are to be submitted on the UB-04 form and individual professional claims should be submitted on the CMS-1500 form. Clean claims must be filed within the

specified contractual time frame.

Clean claim criteria

A cClean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

A clean claim must:

- Ccomply with all standard coding guidelines;
- Ccontain no missing information; and
- Be free of any defect or incorrect or obsolete coding or medical necessity
- be free of any defect or incorrect or obsolete coding, or medical necessity.

A cClean cClaim must include all substantiating documentation that Humana Healthy Horizons ~~in Louisiana the health plan~~ deems necessary for its adjudication~~,~~ and not require special processing or consideration, which would otherwise delay or prevent timely payment of the claim.

A clean claim is one that does not contain a defect or~~,~~ require Humana Healthy Horizons ~~in Louisiana~~ to investigate or develop prior to adjudication and can be processed without obtaining additional provider information. The provider submits a clean claim by providing the required data elements on the standard claim~~s~~ forms along with any attachments and additional information. The required elements of a clean claim must be complete, legible~~,~~ and accurate. Clean claims must be filed within the appropriate time frame.

The aA~~A~~ppendix included in this manual includes sample claim forms from LDH for a CMS-1500 professional services claim and for UB-04 hospital inpatient and outpatient claims. Please note that LDH includes these forms, additional billing instructions and example claims for several different types of service providers and facilities at the below links.

Individual providers who order, prescribe and/or refer (OPR) Medicaid services must be documented on claims. The only exceptions are ~~is~~ nursing evaluations and prevent~~at~~ive screenings. To fulfill claims processing requirements, the l~~L~~ocal e~~E~~ducation a~~A~~gency's (LEA) must input the ordering provider's name, ~~their~~ Type 1 (individual) NPI and DK2 qualifier on all claims.~~-~~

Participating LEA providers should expect claim denials on interim bills submitted for reimbursement if OPR provider enrollment requirements are not complete by Dec~~ember~~ 30, 2023. Individuals currently enrolled as participating Louisiana~~A~~ Medicaid fee-for-service providers are not required to enroll separately as an OPR provider.

Abortion claim requirements

~~In order f~~For induced abortions to be covered, ~~one~~ 1 of the following ~~two~~ 2 requirements must be met:

~~1.~~• A ~~physician~~ provider has found and certifies~~,~~ ~~must submit a claim form, with a diagnosis or medical condition specifying that the pregnancy life is endangered~~in danger. . In addition, a certified statement must be attached to the claim that includes the name~~ and~~, address of the enrollee~~member and~~, advise~~sing that the life of the pregnant woman will be would be endangered~~in danger if the fetus is carried to term.~~that on the basis of the provider's~~ir~~ professional judgement, the life of the pregnant woman would be endangered if the fetus was carried to term. The certification statement must include the name and address of the member~~,~~ and be included on the claim form. The claim form must include the diagnosis or medical condition ~~which~~that makes the pregnancy life endangering.

~~2.~~• If a pregnancy is due to rape or incest:

- ~~A report from law enforcement or a provider's document~~statement ~~must be attached to the claim. or a physician's document~~
- A report of the act to law enforcement or treating ~~physician's~~ provider's statement advising that the victim was ~~too~~ physically or psychologically incapacitated and did not~~to~~ report the rape or incest must be submitted along with the treating ~~physician's~~ provider's claim for reimbursement for performing an abortion.~~-~~
- The member must certif~~ies~~ that the pregnancy is a result of rape or incest and the certification ~~is~~ must be witnessed by the treating ~~physician~~provider.
- The Office of Public Health Certification of Informed Consent-Abortion form is signed and witnessed by the treating ~~physician~~provider.

In order for Medicaid reimbursement to be made for an induced abortion, providers must attach a copy of the ~~"~~Office of Public Health Certification of Informed Consent-Abortion~~"~~ form to the~~ir~~ claim form. The form is available~~is to be obtained~~ from the Louisiana Office of Public Health by completing the following ~~via a~~ Pregnancy Info Materials Request Form~~request form Pregnancy Info Materials Request Form |~~

~~La Dept. of Health~~ or by calling 1~~-~~**504-568-5330**.

As noted above, claims associated with an induced abortion, including claims from the attending provider, hospital, assistant surgeon or anesthesiologist, must be submitted as hard copy (paper) only and accompanied by a copy of the attending provider's certifications, as applicable. ~~As mentioned above, claims associated with an induced abortion, including claims from the following:~~

- attending providerphysician
- hospital
- assistant surgeon
- anesthesiologist

must be submitted as hard copy (paper) only and accompanied by a copy of the attending physician's certifications, as applicable.

CMS-1500 billing instructions

Medicaid will requires all professional service and independent laboratory providers to include a valid CLIA number on all claims submitted for laboratory services, including CLIA waived tests. This information is required tomust be entered into box 23 of the CMS-1500 claim form. T. The CLIA number entered must contain the "X4' qualifier, and the CLIA certification number. T. The CLIA certification number includes the two2-digit state code, followed by the letter "D" and the provider's unique CLIA number. F. For further instructions on how to fill out the CMS-1500 claim form, please visit CMS 1500 billing instructionsBILLING INSTRUCTIONS.: https://www.lamedicaid.com/provweb1/billing_information/CMS_1500.htm.

UB-04 form instructions

The CLIA number is not required for UB-04 claims. For instructions on how to fill out the UB-04 claim form, please visit: UB 04 bBilling iInstructions.https://www.lamedicaid.com/provweb1/billing_information/ub04instructions.htm.

Claims processing time frames

Per our agreement with LDH, Humana Healthy Horizons' in Louisiana's claim processing responsibilities include:

- Performance of an initial screening either to reject or accept the claim within five 5 business days of receipt of the claim.
- Processing either to pay or deny at least 90% of all clean claims within 15 calendar days of receipt of the claim.
- Processing 100% of clean claims (including pended claims) within 30 calendar days of receipt of the claim
    - If the claim remains unpaid beyond the thirty (30), calendar- day clean claim processing deadline, Humana Healthy Horizons shall will pay interest at a rate of twelve percent (12%) per annum, calculated daily for the full period in which a payable claim remains unpaid.
- Payment or denial of all (100%) pended claims within 60 calendar days of the date of receipt

Providers should expect payment at least once a week. In order tTo receive prompt payments, providers should sign up to submit and receive payments electronically.

Providers will be notified when systems updates will take place. Claims denied inappropriately due to system updates will be recycled within 15 calendar days of the system update.

Timely filing

Providers are required to file timely claims/encounters for all Medicaid services rendered. Timely filing is an essential component of Humana Healthcare Effectiveness Data and Information Set (in Louisiana's HEDIS®)* reporting and ultimately can affect how a plan and its providers are measured in member preventive care and screening compliance.

Providers shall submit to Humana Healthy Horizons in Louisiana all claims and, if capitated, shall submit medical encounter data, for services rendered to Medicaid managed care plan members, in accordance with the terms and conditions in the LDH contract. Regardless of agreement specifics, providers or subcontractors agree to submit such claims within 365 calendar days from of the date of service. Encounter data, as applicable, must be submitted to Humana Healthy Horizons within 30 days from the date of service.

Providers, involving third- party liability (excluding Medicare) shall submit claims within 365 calendar days from of the date of service.

When Medicare is the primary insurer, providers shall submit claims to Humana Healthy Horizons in Louisiana within 180 calendar days from of Medicare's explanation of benefits (EOB) of payment or denial.

* HEDIS is a registered trademark of the NCQA.

Claims overpayments

Providers must report, to Humana Healthy Horizons in Louisiana, any service claim overpayments for medical services rendered to Medicaid managed- care-plan members, in accordance with the LDH contract. Regardless of agreement specifics, the provider or subcontractor agree to submit such claims within 60 calendar days after the date on which the overpayment was identified, and to notify Humana in writing of the reason for the overpayment as required by 42 CFR 438.608.

~~to submit such claims within 60 calendar days after the date on which the overpayment was identified, and to notify Humana in writing the reason for the overpayment as required by 42 CFR 438.608.~~

Refund checks for overpayment can be mailed to:
Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655

Humana Healthy Horizons in Louisiana reports all overpayments to LDH Program Integrity within 60 calendar days from of the date the overpayment was identified. These reports include all unsolicited provider refunds.

Suspension of pProvider pPayments

A network provider's claim payments are subject to suspension when LDH has determined there is a credible allegation of fraud in accordance with 42 C.F.R. 455.23. LDH may determine that payments to the provider should not be suspended pending the investigation.

If a network provider's claim payments are suspended, Humana Healthy Horizons in Louisiana will send the provider a notice and appeal rights. Once the suspension period has ended, Humana Healthy Horizons in Louisiana will adjudicate any previously pended claims.

Electronic funds transfer (EFT)/eElectronic remittance advice (ERA)

Electronic claims payments offers several advantages over traditional paper checks:

- Faster payment processing
- Reduced handbook processes

- Access to online or electronic remittance information
- Eliminat[ion of thees] risk of lost or stolen checks

With EFT, your Humana Healthy Horizons [in Louisiana]claim[s] payments are deposited directly in the bank account(s) of your choice. You also will be enrolled for our [electronic remittance advice (]ERA[)], which replaces the paper version of your explanations of remittance.

Note[OTE]**:** Fees may be associated with electronic transactions. Please check with your financial institution or merchant processor for specific rates related to EFT or credit card payments. Check with your clearinghouse for fees associated with ERA transactions.

To enroll for [Electronic Funds Transfer (]EFT[)]/[Electronic Remit Advice (]ERA[)]

Humana Healthy Horizons' [in Louisiana's]provider portal [(Availity Essentials.com)]features an ERA/EFT enrollment tool. To access the tool:

1. Sign in to the portal at Availity Essentials [Availity.com](registration required)[.]
2. From the Payer Spaces menu, select Humana[.]
3. From the Applications tab, select the ERA/EFT Enrollment app
    - [.(]If you don't see the app, contact your Availity Essentials administrator to discuss your need for the tool.[)]

EFT payment transactions are reported with file format CCD+, an [NACHA]a[A]utomated c[C]learing h[H]ouse (ACH) corporate payment format with a single, 80-character addendum record capability; it is the recommended industry standard for EFT payments. The addendum record is used by the originator to provide additional information about the payment to the recipient. This format also is referenced in the ERA (835 data file). Contact your financial institution if you would like to receive this information.

The ERA replaces the paper version of the explanation of reimbursement [(EOR)]. Humana Healthy Horizons delivers 5010 835 versions of all ERA remittance files that are compliant with [the Health Insurance Portability and Accountability Act of 1996 (]HIPAA[)]. Humana Healthy Horizons uses the provider portal as the central gateway for delivery of 835 transactions. You can access your ERA through your claim's clearinghouse or through the secure provider tools available [on Availity Essentials]at Availity Essentials[.com].

Note[OTE]**:** Fees may be associated with ERA transactions. Check with your clearinghouse for specific rates.

Multi[-]payer EFT/ERA enrollment

Following the ERA/EFT enrollment process, you will receive your remittance advice through a claim's clearinghouse. When you enroll, you will be prompted to designate the clearinghouse that [you]should receive your ERA.

Note[OTE]**:** Fees may be associated with electronic transactions. Check with your financial institution for specific rates related to EFT. Check with your clearinghouse for fees related to ERA.

Visit Availity Essentials[.com] for answers to any questions.

Incentive plans

[Upo]On request, the [physician]provider shall agree to disclose to Humana Healthy Horizons [in Louisiana]within 30 days (or less, if required for Humana Healthy Horizons [in Louisiana]to comply with all applicable state and federal laws, rules and regulations) all terms and conditions of any incentive plan between [physicians]providers, as defined by CMS and/or any state or federal law. Disclosure proof includes certification[,] or any other documentation as required by CMS and/or LDH and/or information Humana Healthy Horizons [in Louisiana]requires to comply with applicable state and federal laws, rules and regulations.

[federal law. Disclosure proof includes certification, or any other documentation as required by CMS and/or LDH and/or information Humana Healthy Horizons in Louisiana requires to comply with applicable state and federal laws, rules and regulations.]

Within 35 days of a request by LDH or the U.S. Department of Health and Human[a] Services [(DHHS)], a provider shall:

- Disclose ownership or significant business transactions between the [physician]provider and any wholly owned supplier or subcontractor during the [five]5-year period ending on the date of the request
- Disclose the identity of any owner, agent or managing employee of the [physician]provider who has been convicted of a crime relating to any program under Medicare, Medicaid or [the Title XX]any other federal health care [services]program[.]

Claim status

You can track the progress of submitted claims at any time through ~~Availity Essentials at~~ Availity Essentials~~.com~~. Claim status is updated ~~daily~~ in real time and provides information on claims submitted in the previous 24 months. Searches by member ID ~~number~~ and date of birth, claim number, service dates and HIPPA standard~~,~~ ~~member name and date of birth or claim number~~ are available.

You can find the following claim information on the provider portal:

- Reason for payment or denial
- Check number(s) and date
- ~~•~~ Procedure/diagnostic

•
- Claim payment date

Explanation of pPpayment (EOP)

Explanations of payment (EOPs) are current claim status statements Humana Healthy Horizons in Louisiana sends to providers. EOPs are generated weekly; however, the frequency with which providers receive EOPs depends upon claim activity. Providers who receive EFT payments will receive an electronic remittance advice (ERA) and can access a "human readable" version at Availity Essentials. com.

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA-compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

Code editing

Humana Healthy Horizons in Louisiana uses code editing software to review and ensure the consistency, efficiency and accuracy of diagnosis and procedure codes on submitted claims. Our code editing review may identify coding conflicts or inconsistent information on a claim. For example, a claim may contain a conflict between the patient's age and the procedure code, such as the submission for an adult patient of a procedure code limited to services provided to an infant. Humana Healthy Horizons' in Louisiana's code editing software identifies these conflicts to provide notification to the provider that other information is necessary to permit reimbursement. The code editing review only evaluates the appropriateness of the procedure code, not the medical necessity of the procedure.

Humana Healthy Horizons in Louisiana provides notification of upcoming code editing changes. We publish new code editing rules and our rationales for these changes on the first Friday of each month at

Humana.com/Edits.

Coding and payment policies

Humana Healthy Horizons in Louisiana strives for consistency with LDH, Medicaid and national commercial standards regarding the acceptance, adjudication and payment of claims. These and related clinical standards apply to submitted hard copy or electric code/code set(s).

We apply HIPAA standards to all claims received electronically received claims. Accordingly, we accept only HIPAA-compliant code sets (i.e., HCPCS, Current Procedural Terminology (CPT) and International Classification of Diseases, 10th Revision [(ICD-10]). In addition, the CMS rules for Medicaid coding standards are followed. Generally accepted commercial health insurance rules regarding coding and reimbursement also are used when appropriate. Humana Healthy Horizons strives to follow the prevailing National Correct Coding Initiative (NCCI) Medicaid edits as maintained by CMS.

To determine unit prices for a specific code or service, please visit LDH Fee Index https://www.lamedicaid.com/provweb1/feeschedules/feeschedulesindex.htm..

Humana Healthy Horizons in Louisiana will process accurate and complete provider claims in accordance with Humana's normal claims processing procedures, including, but not limited to, claims processing edits, and claims payment policies, and applicable state and/or federal laws, rules and regulations. See the providers' section of Humana.com to access a summary of changes to claims processing procedures; this summary of changes to claims processing procedures is not intended to be an exhaustive list.

Such claims processing procedures include review of the interaction of a number of factors. The result of Humana Healthy Horizons' in Louisiana's claims processing procedures will beare dependent upon the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most used factors are:

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day, f. For example:
  - Two 2 or more surgeries performed the same day
  - Two 2 or more endoscopic procedures performed the same day
  - Two 2 or more therapy services performed the same day
- Whether a co-surgeon, assistant surgeon, surgical assistant or any other provider who is billing independently is involved
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service

that was provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the member

•

- Whether services can be billed as a complete set of services under one billing code

Humana Healthy Horizons ~~in Louisiana~~ develops claim~~s~~ processing procedures in our sole discretion based on our review of correct coding initiatives, national benchmarks, industry standards~~,~~ and industry sources such as the following, including any successors of the same:

- LDH regulations, manuals and other related guidance
- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee ~~(NUBC)~~ guidance, including the UB-04 Data Specifications Manual
- American Medical Association's (AMA) ~~Current Procedural Terminology (~~CPT®~~)~~ and associated AMA publications and services
- ~~CMS' Healthcare Common Procedure Coding System (~~HCPCS~~)~~ and associated CMS publications and services
- ~~International Classification of Diseases (ICD), 10th edition (~~ICD-10~~)~~
- American Hospital Association's ~~(AHA)~~ Coding Clinic ~~g~~Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services
- ~~Food and Drug Administration (~~FDA~~)~~ guidance
- Medical and surgical specialty societies and associations
- Industry-standard utilization management criteria and/or care guidelines
- Our medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published, peer-reviewed literature

Changes to any one of the sources may lead Humana Healthy Horizons ~~in Louisiana~~ to modify current or adopt new claims processing procedures.

These claim~~s~~ processing procedures may result in a denial of reimbursement, a request for the submission of relevant medical records, prior to or after payment, or the recoupment or refund request of a previous reimbursement. You can access additional information at Humana.com.

Humana Healthy Horizons ~~in Louisiana~~ seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that reviews, upon request, claims that are denied based ~~up~~on the use of certain codes, relationships between codes, unit counts or the use of modifiers. This review takes into consideration the previously mentioned state Medicaid, NCCI and national commercial standards when considering an appeal.

To ensure all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the Humana Healthy Horizons appeals team to consider why the code set(s) and modifier(s) being submitted differ from the standards inherent in our edit logic. The clinical information may provide evidence that overrides the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Specific claims are subject to current Humana Healthy Horizons ~~in Louisiana~~ claim logic and other established coding benchmarks. Consideration of a provider's claim payment concern regarding clinical edit logic will be based ~~up~~on review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Coordination of b~~B~~enefits (COB)

Humana Healthy Horizons ~~in Louisiana~~ collects COB information for our members. This information helps ~~us~~ ensure that we pay claims appropriately and comply with federal regulations that Medicaid programs are the payer of last resort.

While we try to maintain accurate information at all times, we rely on numerous sources for information updated periodically, and some updates may not always be fully reflected on Availity Essentials. Humana Healthy Horizons ~~of Louisiana shall pay the full amount allowed under the appropriate payment schedule for the claim even if an Explanation of Benefit (EOB) is not present and will recoup the payment if an error if payment is found.~~ applies normal lesser of logic for processing COB claims. Payment is based on the lesser of the following calculations:

a~~A~~llowed amount minus other insurance paid amount

~~O~~ or

~~M~~member responsibility on the ~~explanation of benefits (~~EOB, ~~)~~ whichever is less.

Exceptions:

- Louisiana Health Insurance Premium Payment ~~(LaHIPP)~~ members: ~~—~~Humana Healthy Horizons will pay full member responsibility from the other insurance (OI) when processing secondary insurance.
- ~~Rual Health Clinics (~~RHC~~s)~~/~~Federally Qualified Health Clinic (~~FQHC~~s)~~/American Indian c~~C~~linics are reimbursed, making the provider whole, based on the Prospective Payment System (PPS) rate.
-

Louisiana Medicaid uses the pay and chase method of payment for preventive pediatric care services and prescription drug services. Humana Healthy Horizons ~~of Louisiana~~ will seek renumeration for pay and chase claims from the member's other carrier within 60 calendar days of the end of the month in which we paid the claim. If we were not aware of the other coverage prior to paying the claim, we will seek renumeration from the other carrier within 60 calendar days of the end of the month in which we learned of the member's other coverage. Please ask Humana Healthy Horizons ~~in Louisiana~~ members for all healthcare insurance information at the time of each service.

You can search for COB information on Availity Essentials by:

- Member number
- Case number
- Medicaid number/Medicaid Management Information System (MMIS) number
- Member name and date of birth

You can check COB information for members who have been active with Humana Healthy Horizons ~~in Louisiana~~ within the past 12 months.

If you are aware of t~~T~~hird ~~-~~ p~~P~~arty l~~L~~iability (TPL) for a member, contact Louisiana Medicaid's TPL contractor, Gainwell, at **1-225-~~-~~342-8662**. If the request to update TPL is urgent, such as if it is impacting access to care for the member, the provider can contact Humana Healthy Horizons ~~in Louisiana~~ directly. We will verify the request and update our system~~s~~ within ~~four~~ 4 business hours of receiving an urgent TPL request.

Crossover claims

If a recipient has both O~~o~~riginal Medicare and Medicaid coverage, providers should file claims in the appropriate manner with the regional Medicare intermediary/carrier, making sure the recipient's Medicaid number is included on the Medicare claim form. Once the Medicare intermediary/carrier has processed/paid ~~their~~ its percentage of the approved charges, Medicare will electronically submit a ~~"~~crossover~~"~~ claim to the Medicaid f~~F~~iscal ~~i~~Intermediary (FI) - that includes the co-insurance and/~~-~~or deductible. If the ~~"~~crossover~~"~~ claim is denied by Medicare, the provider must submit a corrected claim to Medicare, if applicable. If the ~~"~~crossover~~"~~ claim is not received by the FI from Medicare, ~~then~~ the provider must submit a hard~~-~~copy claim to the FI for payment of Medicaid's responsibility.

Medicaid program rules generally require members to exhaust other insurance coverage, including group health, workers' compensation and no-fault medical payment coverage before claims are submitted to the Medicaid program. Humana Healthy Horizons ~~in Louisiana~~ will coordinate benefits and process as secondary whenever these other forms of coverage are available. When a provider is aware of other coverage, claims should be submitted to the primary payer for a payment determination before claims are submitted to Humana Healthy Horizons. ~~.~~ Claims involving COB will not be processed until an EOB/EOP~~/explanation of benefits (EOB)~~ or EDI payment information file is received, indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (i.e., $0 balance) still must be submitted to Humana Healthy Horizons ~~in Louisiana~~ for processing due to regulatory requirements. Humana Healthy Horizons will follow LDH directives regarding paying specific codes as primary.

~~of benefits (EOB) or EDI payment information file is received, indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (i.e., $0 balance) still must be submitted to Humana Healthy Horizons in Louisiana for processing due to regulatory requirements. Humana will follow LDH directives regarding paying specific codes as primary.~~

COB overpayment

If a provider receives a payment from another carrier after receiving payment from Humana Healthy Horizons ~~in Louisiana~~ for the same items or services, this is considered an overpayment. Humana Healthy Horizons will provide 60 ~~-~~days~~'~~ written notice, or 90 days if a 30-day extension was requested, to the provider before an adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment will be made on a subsequent reimbursement. Providers also can issue refund checks to Humana Healthy Horizons ~~in Louisiana~~ for overpayments and mail them to the following address:

Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655

Providers should not refund money paid to a member by a third party.

Recouping payments

If Humana Healthy Horizons ~~in Louisiana~~ is going to recoup a payment from a provider, written notification will be sent to the provider, including information on the claims and amounts that are being recouped. If the provider disagrees with the recoupment, the provider has ~~y have~~ 60 calendar days from when ~~they receive~~ the written notification was received to send a written response to Humana Healthy Horizons ~~in Louisiana~~, explaining why the recoupment should not be put in place. When Humana Healthy Horizons ~~in Louisiana~~ receives a written response from a provider, Humana Healthy

Horizons ~~in Louisiana~~ has 30 calendar days to review the information provided in the letter, determine whether the facts justify recoupment~~,~~ and provide a written notification of determination, including ~~the~~ rationale for the determination.

When Humana Healthy Horizons ~~in Louisiana~~ recoups payment from a provider, the provider can either remit the amount to Humana Healthy Horizons ~~in Louisiana~~ or permit Humana Healthy Horizons ~~in Louisiana~~ to deduct the amount from future payments that are due to the provider.

Member billing limitations

State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons ~~in Louisiana~~ members for medically necessary covered services, except to collect member cost ~~-~~share, if applicable, and under very limited circumstances. Providers who knowingly and willfully bill a member for a Medicaid-covered service shall be guilty of a felony and, upon conviction, shall be fined, imprisoned or both, as defined in the Social Security Act of 1935.

Humana Healthy Horizons ~~in Louisiana~~ monitors billing policy activity based on member complaints. We implement a tiered approach when working with providers to resolve billing issues. Failure to comply with regulations after intervention may result in both criminal charges and termination of your agreement with Humana Healthy Horizons.

Please remember that government regulations stipulate providers must hold members harmless in the event that Humana Healthy Horizons ~~in Louisiana~~ does not pay for a covered service performed by the provider. Members cannot be billed for services that are administratively denied. The only exception is if a Humana Healthy Horizons ~~in Louisiana~~ member agrees in advance, in writing, to pay for a non-Medicaid covered service. This agreement must be completed prior to providing the service and the member must sign and date the agreement acknowledging ~~his or her~~the member's financial responsibility. The form or type of agreement must specifically state the services or procedures that are not covered by Medicaid.

Please call Humana Healthy Horizons~~'s p P~~rovider s~~S~~ervices at 1-**800-448-3810 (TTY: 711)** for guidance before billing members for services.

Missed appointments

In compliance with federal and state requirements, Humana Healthy Horizons ~~in Louisiana~~ members cannot be billed for missed appointments. Humana Healthy Horizons ~~in Louisiana~~ encourages members to keep scheduled appointments and to call to cancel, if needed.

Louisiana Medicaid may offer transportation assistance to members for healthcare visits. For more information, please call MediT~~t~~rans at 1-**844-613-1638~~.~~ (TTY: 1-800-618-4781)**. MediT~~t~~rans~~Humana~~ provides emergency transportation, as well as non-emergency ambulance transportation, to and from medical appointments when no other means of transportation is available and the member's condition is such that use of any other method of transportation is contraindicated or would make the member susceptible to injury.

If you are concerned about a Humana Healthy Horizons ~~in Louisiana~~ member who misses appointments, please call m~~Care Management Support Services~~Member s~~S~~ervices at 1-**866~~206 0272~~00-448-3810 (TTY: 711)** to refer member to our Case Management Program.

Member termination claim processing

From Humana Healthy Horizons ~~in Louisiana~~ to another plan:
If a member leaves Humana Healthy Horizons' ~~in Louisiana's~~ plan and enrolls in a different Medicaid plan, Humana Healthy Horizons ~~in Louisiana~~ may submit voided encounters to LDH and notify providers of adjusted claims using the following process:

1. On daily receipt of the 834 ~~-~~eligibility file from ~~the Louisiana Department of Health (~~LDH~~)~~, Humana Healthy Horizons~~ws in Louisiana w~~ill identify which members received a retro-eligibility date and require termination of enrollment within the Humana Healthy Horizons claims payment system.
2. Humana Healthy Horizons ~~in Louisiana~~ will initiate the member termination process. This will be completed within ~~five~~ 5 business days of receipt of the 834 file.
3. Humana Healthy Horizons ~~in Louisiana~~ will determine whether claims for rendered service~~(~~s~~)~~ were paid after the member's Humana Healthy Horizons ~~in Louisiana~~ Medicaid benefits ended. This process will be completed within ~~five~~ 5 business days.
4. Humana Healthy Horizons ~~in Louisiana~~ will notify affected providers that recoupment of payment will occur for the claim(s) identified in the recoupment letter. The provider will have 60 calendar days to respond to the notice.
5. If the affected provider has not appealed the recoupment payment or submitted a refund check within 60 calendar days, Humana Healthy Horizons ~~in Louisiana~~ will adjust the payment(s) for the affected claims listed in the notice letter. This will take place within 10 business days.
6. The provider will receive an EOP reflecting the funds recouped. This will take place within ~~five~~ 5 business days of completion of payment adjustment(s).
7. After the recoupment has received a processed date stamp, a voided encounter for the affected claims will be submitted to LDH ~~within 10 business days,~~ assuming the original submitted encounter was previously accepted. Please note that if the original encounter was denied or rejected by LDH, a void does not need to occur.
8. Upon successful completion of the encounter-void process, affected providers will be sent a courtesy letter informing them that the original payment was successfully cleared from the LDH system and that they can proceed to bill the claim(s) with the member's active Medicaid plan. This will happen within five business days. Please note that if the state did not accept the voided encounter, the process may be delayed an additional 10 business days.

If the provider experiences continued issues receiving payment from another Medicaid plan within 60 days of the issued EOP reflecting recoupment of payments and the issued courtesy letter, Humana Healthy Horizons in Louisiana encourages providers to contact the member's current Medicaid managed care plan for the claim(s) dates of service.

From another plan to Humana Healthy Horizons in Louisiana:

If a member was previously enrolled with another Medicaid plan and is now eligible with Humana Healthy Horizons in Louisiana, providers are required to submit a copy of the EOP reflecting recoupment of payment and documentation from the previous managed care organization to validate the original encounter has been voided and accepted by LDH.

Providers have up to 365 calendar days from the date of service or 180 calendar days from the member's MCO linkage add date, whichever is later, to submit claims to the Humana Healthy Horizons in Louisiana for dates of service during the retrospective enrollment period.

ChapterHAPTER 7VII: Reconsiderations, appeals and complaints ECONSIDERATIONS, APPEALS AND COMPLAINTS

Claim rReconsiderations

Providers can submit a reconsideration request for those provider claims or group of claims that have been denied, partially denieddenied, or underpaid within 180 calendar days following the date such claim was paid, denieddenied, or not paid by the required date by Humana Healthy Horizons. Providers can submit claim reconsiderations through any avenue, such as the Provider Customer Care unit, their Provider Relations representative, written correspondence via the Humana Healthy Horizons in Louisiana mailing address or the Pprovider Rrelations email address, or the provider portal. Providers shall provide the following information, at a minimum, in a clear and acceptable written format:

- Member name and identification number,
- Date of service,
- Relationship of the member to the patient,
- Claim number,
- Name of the provider of the services,
- Charge amount, payment amount, the allegedly correct payment amount and the, difference between the amount paid and the allegedly correct payment amount, and;
- Brief explanation of the basis for the contestation.
-

Provider claim reconsiderations will be r:

- Resolved within 30 business days of receipt of the reconsideration request.
- Claims will be reprocessed when the resolution determinesdetermines whether the claim was paid or denied incorrectly, within 30 business days of receipt of the request for reconsideration.
- A resolution letter will be sent to the provider within 30 business days of receipt of the reconsideration request. A provider claim reconsideration may be filed using any of these methods:

Online:

Providers claim reconsiderations about finalized claims may be submitted online via Availity Essentials.
To begin, sign in at Availity Essentials.com, and use the cClaim sStatus tool to locate the claim and click select the "Dispute Claim" button. Then go to the request in the Appeals worklist (located under "Claims & Payments") to supply needed information and documentation and submit the request to Humana Healthy Horizons in Louisiana. Status and high-level Humana Healthy Horizons in Louisiana determination for claim disputes submitted online can be viewed in the Appeals worklist. For training opportunities, visit Humana.com/ProviderWebinars.

Phone:

Providers can verbally submit a rReconsideration by calling 1-**800-448-3810 (TTY: 711)**, Monday – Friday, from 7 a.m. – 7 p.m., Central time Monday – Friday.

Mail:

Providers can submit rReconsiderations in writing via mail by usingat this the following address:

Humana Healthy Horizons in Louisiana
Provider Reconsiderations
P.O. Box 14601
Lexington, KY 40512-4601

Or via an email to:

LAMedicaidProviderRelations@humana.com

Claim aAppeals

If the provider is dissatisfied with the determination of the claim reconsideration, providers may request a second level review referred to as a claim appeal.If thea provider is dissatisfied with the claim reconsideration's determination, the providers may request a second-level review called a claim appeal. Providers may submit a written appeal within 30 90 calendar days from the date on the determination letter for claims reconsideration. Humana Healthy Horizons in Louisiana will review and provide a determination within thirty (30) calendar days or any successor date whichthat may be required.

~~calendar days or any successor date which may be required.~~

Providers should follow the appeal process:

- A provider's request for claim reconsideration is required before requesting a provider claim appeal.
- ~~Providers or their authorized representative have the option to submit an appeal following the claim reconsideration process.~~Providers or their authorized representative can submit an appeal after the claim reconsideration process. ~~The p~~Providers must submit any documentation from the claim reconsideration request when submitting a provider appeal.
- ~~If the appeal is on behalf of a member, written authorization from the member or his or her legal representative must be submitted, along with all required documents, prior to beginning the process.~~If the appeal is on behalf of a member, written authorization from the member or the member's~~ir~~ legal representative must be submitted, along with all required documents, before beginning the process. The appeal will be processed under the member's name.
- In any instance where a ~~provider~~provider's claim is denied, the consent of the member who received services ~~shall~~ is not ~~be~~ required for the provider to dispute the denial of the claim.
- Additional or new clinical documents sent to Humana Healthy Horizons will be reviewed by the medical director to determine if the additional clinical documents will support the appeal in meeting medical necessity.
- A resolution letter will be mailed within 30 calendar days from receipt of the appeal.

Providers can file an appeal in writing to:

Humana Healthy Horizons in Louisiana
Provider Appeals
P.O. Box 14601
Lexington, KY 40512-4601

Binding arbitration

In the event the provider has completed the reconsideration and appeal process and remains dissatisfied with Humana Healthy Horizons' ~~in Louisiana's~~ determination, the provider has the option to request binding arbitration for claims that have been denied, partially ~~denied~~denied~~,~~ or underpaid, or for a bundle of claims within 30 calendar days from the date of the appeal determination. The request should include decisions from all claim reconsideration requests and claim appeals. The arbitrator must be certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If you and Humana Healthy Horizons ~~in Louisiana~~ are unable to agree on an association, the rules of the American Arbitration Association will apply. The arbitrator shall have experience and expertise in the healthcare field and ~~shall~~ be selected according to the rules of ~~his/ her~~ the arbitrator's ~~ir~~ certifying association. Arbitration conducted pursuant to this section ~~shall be~~is binding on all parties. The arbitrator ~~shall~~ will conduct a hearing and issue a final ruling within 90 days of being ~~selected, unless~~selected unless ~~you~~the provider and Humana Healthy Horizons ~~in Louisiana~~ mutually agree to extend the deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

Providers should review their contract with Humana Healthy Horizons ~~in Louisiana~~ for any specific language related to arbitration. Email binding arbitration requests to ~~H~~humana~~H~~ealthy~~H~~orizons~~L~~ouisiana@humana.com.

Note: Per House Bill No. 492, Act No. 349, an adverse determination involved in litigation or arbitration or not associated with a Medicaid ~~enrollee~~member ~~shall~~ will not be eligible for independent review.

Independent r~~R~~eview

The i~~I~~ndependent r~~R~~eview process was established by Louisiana Revised Statutes ~~La-RS~~ 46:460.81, et seq., to resolve claim~~s~~ disputes when a provider believes an MCO has partially or totally denied claims incorrectly. The rendering provider must submit an i~~I~~ndependent ~~r~~Reconsideration r~~R~~eview reconsideration (IRR) to Humana Healthy Horizons ~~in Louisiana~~ before requesting an independent r~~R~~eview from LDH. If Humana Healthy Horizons ~~in Louisiana~~ upholds the adverse determination, the~~n~~ provider has 60 calendar days to request an independent review from the Health Plan Management d~~D~~epartment at LDH. Please note, post-payment reviews conducted by the Special Investigations Unit (SIU) do not meet the criteria for i~~I~~ndependent r~~R~~eview and are exempt from this process except for ~~mental health rehabilitation (~~MHR~~)~~ service providers. MHR service providers have the right to an i~~I~~ndependent r~~R~~eview for recoupments related to an adverse determination resulting from fraud, waste or abuse.

Subject to review by LDH, providers may aggregate multiple adverse determinations involving Humana Healthy Horizons ~~in Louisiana~~ when the specific reason for nonpayment of the claims aggregated involves a dispute regarding a common

substantive question of fact or law. If a provider elects to aggregate its claims, the independent reviewer may, upon request, allow for up to an additional 30 days to provide relevant information related to the independent review requests.

~~when the specific reason for nonpayment of the claims aggregated involveinvolves a dispute regarding a common substantive question of fact or law. If a provider elects to aggregate its claims, the independent reviewer may, upon request, allow for up to an additional 30 days to provide relevant information related to the independent review requests.~~

Independent review is a ~~two~~2-step process~~:.~~

Step ~~One~~1:
Submit a request for ~~independent review reconsideration (~~IRR~~)~~ to Humana Healthy Horizons ~~in Louisiana~~ within 180 calendar days from ~~one~~ 1 of the following:

- Date on which the MCO transmitted remittance advice or notice of claim denial.
- 60 days from the date the claim was submitted to the MCO if the provider receives no notice from the MCO either partially or totally denying the claim.
- Date on which the MCO recoups payment for a previously paid claim.

Humana Healthy Horizons in Louisiana will acknowledge in writing receipt of the IRR request within 5 calendar days of receipt. A final decision ofon the request will be rendered within 45 calendar days, unlessdays unless another time frametime period has been agreed upon in writing.

Step Two2:
If Humana Healthy Horizons in Louisiana upholds the adverse determination or does not respond to the IRR request within the allowed 45 calendar days, the provider may then submit the iIndependent rReview to LDH. LDH must receive the IRR request within:

- 60 days of the date the provider received the MCO decision of the IRR request, or
- iIf the provider does not receive a decision within the 45-calendar day time frame, the provider has 60 days from the date the IRR was submitted to Humana Healthy Horizons to request an independent review from LDH.

Providers can expect the following after requesting an independent review:
- LDH will determine eligibility for review within 10 business days.
- The independent reviewer will contact providers within 14 calendar days to request all information and documentation regarding the disputed claim or claims.
- All information and documentation must be received within 30 calendar days of the independent reviewer's request. The independent reviewer will not consider any information or documentation not received withinreceived outside the 30-day time frame.
- The independent reviewer will provide a resolution within 60 calendar days.
- The independent reviewer may request in writing an extension of time from LDH to resolve the dispute. If an extension of time is granted by LDH, then the independent reviewer shall provide notice of the extension time to both the provider and Humana.If an extension of time is granted by LDH, the independent reviewer shall give notice of the extension time to the provider and Humana Healthy Horizons.
- If the independent reviewer renders a decision requiring Humana Healthy Horizons in Louisiana to pay any claims or portion of the claims, then Humana Healthy Horizons will send the payment within 20 days of the reviewer's decision.
- Within 10 days of the reviewer's decision, the provider shall reimburse Humana Healthy Horizons in Louisiana for the fee associated with conducting an independent review when if Humana Healthy Horizons' in Louisiana's appeal decision is upheld.
- Within 60 days of the independent reviewer's decision, either the provider or Humana Healthy Horizons in Louisiana may file suit in any court having jurisdiction to review the independent reviewer's decision and to recover any funds awarded by the independent reviewer to the other party. Any claim concerning an independent reviewer's decision that is not brought within 60 days of the decision shall be barred indefinitely.

Note: Per House Bill No. 492, Act No. 349, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrolleemember shall not be eligible for independent review. There is a $750 fee associated with an IRR request. If the independent reviewer decides in favor of the provider, the MCO is responsible for paying the fee. If the reviewer finds in favor of the MCO, the provider is responsible for paying the fee.

IRR forms:
Humana: Independent rReview rRequest fForm—Humana
LDH: Independent rReview rRequest fForm—LDHLa Dept. of Health

Provider iIssue eEscalation and rResolution

In the event a provider remains dissatisfied with the dispute determination, the provider may file a written complaint or request for escalation related to Humana Healthy Horizons in Louisiana policy, proceduresprocedures, or payments. Providers may also file complaints including but not limitedlimited to issues related to health plan staff, contracted vendors, or formulariesy.

Providers may file a complaint about:
- Benefits and limitations.
- Eligibility and enrollment of a member or care provider.
- Member issues or Humana Healthy Horizons plan issues.

- Availability of health services from Humana Healthy Horizons ~~in Louisiana~~ to a member~~.~~
- Delivery of health services~~.~~
- Quality of service~~.~~

A provider complaint can be filed verbally, in writing or in person using any of the following methods:

Phone:
Providers can verbally submit a ~~provider~~ complaint by calling 1-**800-448-3810** (TTY: 711), Monday – Friday, ~~from~~ 7 a.m. – 7 p.m.~~, Central time Monday – Friday.~~

Mail:
Providers can submit a complaint in writing ~~via mail by~~ using ~~this~~ the following address:

~~Humana Healthy Horizons in Louisiana~~
~~Provider Reconsiderations~~

~~P.O. Box 14601~~

~~Lexington, KY 40512-4601~~ Humana Healthy Horizons in Louisiana
~~-~~Attn: Provider Relations
~~-~~1 Galleria Blvd., Suite 1000
~~-~~Metairie, LA 70001-2081

In person: Contact your Provider Relations r~~R~~epresentative to file in person.

Email:

~~Or via an email to:~~
LAMedicaidProviderRelations@humana.com

Louisiana Department of Health dispute process

If, after exhausting the above outlined provider complaint or claim dispute process, and the provider remains dissatisfied or has not receive a timely response, a dispute can be filed directly with LDH via ProviderRelations@la.gov. LDH requests that providers be sure to include details on attempts to resolve the issue at the health plan level as well as contact information (contact name, provider name, e~~-~~mail address and phone number) so that LDH staff can follow up with any questions.

Member g~~G~~rievance and a~~A~~ppeal system process

The following section ~~below~~ is taken from Humana Healthy Horizons' ~~in Louisiana's~~ member grievance and appeal procedure as set forth in the Humana Healthy Horizons ~~-~~member handbook. This information is provided so that you may assist Humana Healthy Horizons ~~in Louisiana~~ members in this process, should they request it. Please contact your provider contracting representative with any questions you have about this process.

The Humana Healthy Horizons ~~in Louisiana~~ representatives who handle member grievances and appeals maintain appropriate records of complaints containing the reason, date and results.

Filing a grievance or appeal
If ~~a~~ member~~s~~ have ~~has~~ questions or ~~an~~ issue~~s~~, ~~he or she~~they can call 1-**800-448-3810** (TTY: 711), Monday through Friday, ~~from~~ 7 a.m. to 7 p.m.~~ Central time.~~ If dissatisfied with the answers from ~~customer service~~Customer Care, the member can file a grievance or appeal.

Members can call C~~c~~ustomer Care~~service~~ to file a grievance or ~~an~~ appeal. To file a grievance or appeal in writing, the member may send us a letter, complete a form obtained from our website~~,~~ or call ~~customer service~~Customer Care. If a member requests a form from Humana Healthy Horizons ~~in Louisiana~~, it will be mailed within ~~three~~ 3 working days. When filling out the form, the member can request help from Humana Healthy Horizons ~~in Louisiana~~ associates.

All grievances and appeals will be considered. The member can have someone help during the process, whether it is a provider or someone else.

The member has the right to continue services during the appeal process. If the member would like services to continue, the member must submit an appeal within 10 calendar days after the notice of action is mailed~~,~~; or within 10 calendar days after the intended effective date of action, whichever is later.

The grievance or appeal submission should include the following:
- Name, address, telephone number and Humana Healthy Horizons ~~in Louisiana~~ member ID number
- Facts and details of actions taken to correct the issue
- What action would resolve the grievance or appeal
- Member's signature
- Date

Grievance review timelines

The member has the right to file a written or verbal grievance. The grievance process may take up to 90 calendar days; however, Humana Healthy Horizons ~~in Louisiana~~ will resolve the member's grievance as quickly as ~~his/her~~the ~~ir~~ health condition requires. A letter explaining the outcome of the grievance will be sent within 90 calendar days ~~from~~ of the date Humana Healthy Horizons ~~in Louisiana~~ receives the request.

Louisiana Medicaid grievance first-level review

Topic	Response
In what manner may the grievance be submitted?	Oral or written
What is the time frame to submit a grievance?	Unlimited
Is an appointment of representativeon (AOR) required?	Yes
Is an acknowledgment of the grievance required?	Yes, within five 5 business days of receipt
What is the resolution time frame?	No later than 90 calendar days after receipt

Appeal review timelines

A member must file the appeal either verbally or in writing within 60 calendar days of the receipt ofdate on the notice of adverse action. The date of the oral notice appeal request will be considered the date of receipt. Humana Healthy Horizons in Louisiana will resolve the appeal as quickly as the health condition requires. A letter telling the member the outcome of the appeal will be sent within 30 calendar days of the date Humana Healthy Horizons in Louisiana receives the request. T. The member has the right to review his/herthe member's case before and during the appeal process.

Louisiana Medicaid appeal first-level review

Topic	Response
In what manner may the appeal be submitted?	Oral or written If the request is submitted orally, the date the oral appealof request is made is considered the date of receipt.
What is the time frame to submit the appeal?	Within 60 calendar days from the date of on the notice of adverse action
Is an appointment of representation (AOR) required?	Yes
Is an acknowledgment of the appeal required?	Yes, within five 5 business days receipt of the appeal
What is the decision notification method?	Written
What is the decision time frame?	Appeal determinations should be rendered aAs expeditiously as the member's health condition requires, but no later than 30 calendar days from receipt, whether received orally or in writing.

Expedited appeal process

The member has the right to request an expedited verbal or written appeal when taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. The member or his/herthe member's ir legal representative can file an urgent or expedited appeal. These appeals are resolved within 72 hours. When making an appeal, the member or the representative needs to notify inform Humana Healthy Horizons in Louisiana that this is an "urgent" or "expedited" appeal. An expedited appeal may be made by calling 1-**800-448-3810 (TTY: 711)**. If it is determined that an expedited process is not required, then the appeal will go through the normal process.

Note**OTE:** Humana Healthy Horizons in Louisiana does not discriminate against a provider or take punitive action against a provider who requests an expedited resolution or supports a member's appeal, as required by 42 CFR 438.410(b).

Louisiana Medicaid expedited appeal first-level review

Topic	Response
In what manner may the appeal be submitted?	Oral or written
What is the time frame to submit the appeal?	Within 60 calendar days from the date of the notice of action
Is an appointment of representation (AOR) required?	Yes
What is the decision notification method?	Oral notification followed by written notification within two days

What is the decision time frame?	As expeditiously as the member's health condition requires but not to exceed 72 hours after receipt, whether the request was submitted orally or in writing

State fFair hHearing

If a member is dissatisfied with Humana Healthy Horizons' ~~in Louisiana's~~ appeal decision, ~~he/she~~the membery~~ can ask for a sState fFair hHearing. With the member's permission~~,~~ and a signed consent form~~,~~ providers may ask (on the member's behalf) for a sState fFair hHearing from ~~the Louisiana Department of Health~~LDH.

A member may seek a sState fFair hHearing after exhausting Humana Healthy Horizons'~~s~~ appeal process. A member who has exhausted Humana Healthy Horizons' ~~in Louisiana's~~ appeal process may file a request for a sState fFair hHearing within 120 calendar days of ~~receipt~~ the date on ~~of~~ Humana Healthy Horizons' ~~in Louisiana's~~ notice of resolution.

A state fair hearing request can be filed:

By mail:
Division of Administrative Law~~,~~
ATTN: HH Section
P.O. Box 4189
Baton Rouge, LA 70821-4189

By fax: **1-225-219-9823**

~~By web~~Online: ~~adminlaw.state.la.us/HH.htm~~Louisiana Division of Administrative Law

The member has the right to continue to receive benefits during a sState fFair hHearing, if the member files for continuation of benefits within 10 calendar days after Humana Healthy Horizons ~~in Louisiana~~ sends a notice of appeal resolution that is not fully in the member's favor.

ChapterHAPTER 8VIII: Quality and complianceUALITY AND COMPLIANCE

Quality improvement

Humana Healthy Horizons ~~in Louisiana~~ has a comprehensive quality improvement program that encompasses clinical care, preventive care, population health management and the health plan's administrative functions. To receive a written copy of Humana Healthy Horizons' ~~in Louisiana's~~ quality improvement program and its progress toward goals, call **1-800-448-3810 (TTY: 711)**.

Participating providers agree to ~~allow and~~ assist Humana Healthy Horizons in Louisiana with its performance ~~of~~ in the following quality management ~~activities~~functions:

Health records review ~~—~~ cConducted to meet requirements of accrediting agencies and~~,~~ federal and state law requirements. Annually, Humana Healthy Horizons ~~in Louisiana~~ may review a sample of clinical records for Humana Healthy Horizons ~~in Louisiana~~ members. Humana Healthy Horizons ~~in Louisiana~~ does not review all records and is not responsible for ensuring the adequacy or completeness of records.

HEDIS ~~—~~ aA set of performance measures. Humana Healthy Horizons ~~in Louisiana~~ may conduct medical record reviews to identify gaps in care for Humana Healthy Horizons ~~in Louisiana~~ members. HEDIS includes care coordination measures for members transitioning from a hospital or emergency department to home for which hospitals and providers have additional responsibilities. In addition to

medical record reviews, information for HEDIS is gathered administratively via claims, ~~encounters and~~encounters and submitted supplemental data. There are ~~two~~ 2 primary routes for supplemental data: ~~—~~ non-standard and standard.

Non-standard supplemental data ~~—~~ iInvolves ~~directly~~ submitting scanned images (e.g., PDF documents) of completed attestation forms and medical records directly. Nonstandard data also can be accepted electronically via proprietary electronic attestation forms (EAF) or practitioner assessment forms (PAF). Nonstandard supplemental data is subject to audit by a team of nurse reviewers prior to closing HEDIS opportunities.

~~reviewers prior to closing HEDIS opportunities.~~

Standard supplemental data ~~—~~ fFlows directly from one electronic database (e.g., population health system, eElectronic mMedical Rrecords) to another without handbook interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-specific custom reports extracted directly from the provider's EMR or population health tool and is submitted to Humana Healthy Horizons via either secure email or FTP transmission. We also accept lab data files in the same way. Humana Healthy Horizons partners with various EMRs to provide member ~~summaries~~summary and detail reports and ~~to~~ automatically retrieve scanned

charts.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)~~**CAHPS®** — The Consumer Assessment of Healthcare Providers and Systems (CAHPS)~~ survey includes several measures that reflect member satisfaction with the care and service provided by the ~~physician~~provider.

Occurrences and adverse events reporting—uUnexpected occurrences and adverse events involving members' quality of care, are reported to Humana Healthy Horizons by providers, precertification nurses and case managers. Cases are reviewed according to Humana Healthy Horizons's policies and, as applicable, the peer-review process, as required by law and accrediting agencies.

Member complaints—mMember complaints and grievances pertaining to quality of care and concerns, which may be referred to the Quality Operations dDepartment for review.

Maintain a health information system—a system that collects, integrates, analyzes and reports data necessary to implement the quality improvement program.

Initiate performance improvement projects (PIPs)—pProjects that address those areas that have been identified as healthcare priorities for our members, or topics that are mandated by LDH.

Preventive guidelines and clinical practice guidelines

These protocols incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources such as professional medical associations, voluntary health organizations and NIH Centers and Institutes. They help providers make decisions regarding appropriate healthcare for specific clinical circumstances. We strongly encourage providers to use these guidelines and to consider these guidelines whenever they promote positive outcomes for clients. The provider remains responsible for ultimately determining the applicable treatment for each individual.

Use of these guidelines allows Humana Healthy Horizons in Louisiana to measure their impact on care outcomes. Humana Healthy Horizons in Louisiana monitors provider guideline implementation through claim, pharmacypharmacy, and utilization data.

Preventive health guidelines and clinical practice guidelines are distributed to all new and existing providers through the following formats:

- Provider manual updates
- Provider newsletters
- Provider website

Providers also can receive preventive health and clinical practice guidelines through the care management department or their Pprovider Rrelations representative. Preventive guidelines and clinical practice guidelines also are available at Humana.com/providers.

Quality performance measures

Quality member care is the cornerstone of Humana Healthy Horizons' in Louisiana's lasting commitment to make a difference. Humana Healthy Horizons uses HEDIS® as one measure of the quality of care delivered to Humana Healthy Horizons members.

The National Committee for Quality Assurance (NCQA) accredits and certifies a wide range of healthcare organizations and manages the evolution of HEDIS, the performance measurement tool used by more than 90% of the nation's health plans. HEDIS scores are compiled using claims and medical records. Humana Healthy Horizons in Louisiana also utilizes performance measures developed in collaboration with the state and the eExternal qQuality rReview oOrganization (EQRO), based on key areas of interest for the population we serve. HEDIS measure targets will be equal to or above the NCQA Quality Compass Medicaid MCO National 50th percentile values for the prior measurement year. When necessary, targets for non-HEDIS measures will be established annually by LDH based on historical performance among health plans.

~~of interest for the population we serve. HEDIS measure targets will be equal to or above the NCQA Quality Compass Medicaid MCO National 50th percentile values for the prior measurement year. When necessary, targets for non-HEDIS measures will be established annually by LDH based on historical performance among health plans.~~

These measures align with LDH initiatives. The full complement of measures address access to, timeliness of and quality of care provided to children, adolescents and adults enrolled in managed care organizationsMCOs and focuses on preventive care, health screenings and prenatal care, as well as special populations.

Quality Assessment and Performance Improvement (QAPI) program

Humana Healthy Horizons in Louisiana has a QAPI program that includes, but is not limited to, the following elements:

- Performance improvement projects
- Overutilization- and under-utilization measures

- Annual analysis of plan clinical, ~~geographical~~geographical~~,~~ and cultural demographics including identification of high-risk populations, areas of network need, member education opportunities and performance improvement opportunities
- Assessment of network provider access and availability, including after-hours availability of ~~primary care providers~~PCPs
- Assessment of quality and appropriateness of care furnished to children with special healthcare needs
- Continuity and coordination of care
- HEDIS measurement
- ~~Consumer Assessment of Health Plan Survey (~~CAHPS~~)~~
- Annual measurement of effectiveness review of the QAPI

- ~~Annual measurement of effectiveness review of the QAPI~~

External quality reviews

Through our contract with the state, we are required to participate in periodic medical record reviews. LDH retains an ~~external quality review organization (~~EQRO~~)~~ to conduct medical record reviews for Humana Healthy Horizons ~~in Louisiana~~ members.

Health record review

~~You~~ Providers may periodically receive requests for medical record copies for review from an EQRO or Humana Healthy Horizons ~~in Louisiana~~. A p~~Your P~~rovider's contract with Humana Healthy Horizons ~~in Louisiana~~ requires that ~~you furnish~~ member medical records are furnished to us for this purpose. EQRO reviews are a permitted disclosure of a member's ~~personal~~ protected health information (PHI) in accordance with HIPAA. We plan to share the results of these studies and work to achieve the best healthcare possible for our members.

Humana Healthy Horizons ~~in Louisiana~~ realizes that supplying medical records for review requires your staff's valuable time, and we appreciate your cooperation with our requests and associated timelines. As LDH requires, Humana Healthy Horizons ~~in Louisiana~~ will review medical records to ensure they are ~~medical record is~~:

- Accurate and legible
- Safeguarded against loss, destruction or unauthorized use
- Maintained in an organized fashion, for all members evaluated or treated
- Readily available for review and provide~~s~~ medical and other clinical data required for q~~Q~~uality and Utilization Management ~~UM~~ Review

Humana Healthy Horizons ~~in Louisiana~~ will ensure ~~the~~ medical record~~s~~ include~~s~~ at least the following:

- Member identifying information~~,~~ including name, identification number, date of birth, sex and legal guardianship (as applicable)
- Primary language spoken by the member and any translation needs
- Services provided, date of service, service site~~,~~ and name of service provider
- Medical history, diagnoses, treatment prescribed, therapy ~~prescribed~~prescribed~~,~~ and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the contractor
- Referrals including follow-up and outcome of referrals
- Documentation of emergency and/or after-hours encounters and follow-up
- Signed and dated consent forms (as applicable)
- Documentation of immunization status
- Documentation of advance directives, as appropriate
- Documentation of each visit must include:
  - Date and begin and end times of the service
  - Chief complaint or purpose of the visit
  - Diagnoses or medical impressions
  - Objective findings
  - Patient assessment findings
  - Studies ordered and results of those studies
  - Medications prescribed
  - Health education provided
  - Name and credentials of the provider rendering services and the signature or initials of the provider ~~and~~
    - ~~•~~ Provider i~~I~~nitials ~~of providers~~ must be identified with correlating signatures

- Consider using preprinted forms to document all aspects of comprehensive services such as EPSDT screening visits~~,~~ (comprehensive health and developmental history, an unclothed physical exam, immunizations, laboratory tests~~,~~ and health education and guidance for parents and children, etc.)

We appreciate your attention to detail in chart documentation.

Value-based payment (VBP) programs

Humana Healthy Horizons ~~in Louisiana~~ is committed to fostering high~~-~~value care in the communities we serve. We have developed ~~value-based payment~~VBP programs that allow providers to earn financial incentives based on quality and clinical outcomes. The programs are designed based on the provider's panel size and readiness. Humana Healthy Horizons offers practice support to facilitate participation and advancement in these programs. Program terms and metrics are reviewed

annually and modified as appropriate. Any earned performance-based payments are made in arrears to allow for reporting and data collectionn. Quality (pay-for-performance) incentives are reviewed and reimbursed annually, one quarter in arrears to allow for reporting/data collection. Shared savings or two-sided arrangements are reconciled on an agreement-specific basis.

allow providers to earn financial incentives based on quality and clinical outcomes. The programs are designed based on the provider's panel size and readiness. Humana Healthy Horizons offers practice support to facilitate participation and advancement in these programs. Program terms and metrics are reviewed annually and modified as appropriate. Any earned performance-based payments are made in arrears to allow for reporting and data collection. Quality (pay-for-performance) incentives are reviewed and reimbursed annually, one quarter in arrears to allow for reporting/data collection. Shared savings or two-sided arrangements are reconciled on an agreement-specific basis.

To learn more about Humana Healthy Horizons' ~~in Louisiana's value-based payment~~VBP programs, including whether you qualify, and other quality programs available through Humana Healthy Horizons, please contact your Provider Relations representative or Provider Engagement associate.

Compliance and ethics

Humana Healthy Horizons ~~in Louisiana~~ serves a variety of audiences~~—~~—members, providers, government regulators and community partners~~—~~—by working together with honesty, respect and integrity. We are all responsible for complying with applicable state and federal regulations as well as applicable Humana Healthy Horizons policies and procedures.

Because Humana Healthy Horizons ~~in Louisiana~~ is committed to conducting business in a legal and ethical environment, its compliance plan:

- Formalizes Humana Healthy Horizons' ~~in Louisiana's~~ commitment to honest communication with our providers, members, employees and ~~-~~community
- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state and federal laws and regulations
- Implements an early detection reporting system to address non~~-~~compliance with laws and regulations; Humana Healthy Horizons ~~in Louisiana~~ policy; professional, ethical or legal standards; and fraud, waste and abuse concerns
- Allows Humana Healthy Horizons ~~in Louisiana~~ to resolve problems promptly and ~~to~~ minimize negative impact on our members or business that could include financial losses, civil damages, penalties and sanctions

General compliance and ethics expectations for providers include:

- Adhering to professional ethics and business standards
- Notifying Humana Healthy Horizons ~~in Louisiana~~ of suspected violations, misconduct or fraud, waste and abuse concerns
- Full cooperation with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations
- Seeking guidance for clarification regarding proper protocol

For questions about provider expectations, please call your Provider Relations representative or ~~pcall P~~rovider ~~sS~~ervices at 1~~-~~**800-448-3810 (TTY: 711)**. ~~We appreciate your commitment to compliance with ethics standards and reporting identified or alleged violations of such matters.~~

Fraud, waste and abuse policy

Providers must integrate specific controls into their practice operations to help ensure prevention and detection of potential or suspected fraud, waste and abuse. Provider staff also must ~~also~~ be educated about the False Claims Act's prohibition on submitting false or fraudulent claims for payment, the penalties for false claims and statements, whistleblower protections and each person's responsibility to prevent and detect fraud, waste and abuse.

Humana Healthy Horizons ~~in Louisiana~~ and LDH should be notified immediately if a provider or office employee:

- Is aware of any provider that may be billing inappropriately~~,~~ (e.g., falsifying diagnosis codes and/or CPT codes, or billing for services not rendered)
- Is aware of a member intentionally permitting others to use ~~his/her~~their member ID card to obtain services or supplies from Humana Healthy Horizons ~~in Louisiana~~ or any authorized plan provider
- Is suspicious that someone is using another member's ID card
- Has evidence that a member knowingly provided fraudulent information on ~~his or her~~the member's enrollment form that materially affects the member's plan eligibility

Information can be reported via an anonymous phone call to Humana's Fraud Hotline at 1~~-~~**800-614-4126**. All information will be kept confidential. Entities are protected from retaliation under 31 U~~.~~S~~.~~C. 3730 (h) for False Claims Act complaints. Humana enforces a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct. Providers also may contact Humana at 1~~-~~**800-4HUMANA (~~800~~ 448-6262)** and Louisiana's Medicaid Fraud, Waste and Abuse Hotline at 1~~-~~**800-488-2917**.
~~**(TTY: 800-220-5404)**~~.

In addition, providers may use the following contacts:

Telephonic:

~~• Special Investigations Unit (SIU) direct line:~~
~~**800-558-4444**, ext. 1500724~~
~~(Monday-Friday, 8 a.m. – 5:30 p.m. Central time~~

- Special Investigations Unit Hotline: 1-**800-614-4126** (24/7 access)
- Ethics Help Line: 1-**877-5-THE-KEY (~~877-~~584-3539)**

Email: siureferrals@humana.com or ethics@humana.com

Web: Ethics Hhelp Lline.com or Humana.com

Chapter 9HAPTER IX: Specialized behavioral healthPECIALIZED BEHAVIORAL HEALTH

Objectives of the bBehavioral hHealth pProgram

Humana Healthy Horizons in Louisiana takes a holistic, multi-faceted approach to member care, with the understanding that behavioral health issues can have a negative impact on an individual's social factors and physical health, which can interfere with a person's their ability to live a full, healthy and productive life. Through integration, our behavioral health program assists our members in achieving lifelong well-being and meeting their personal goals by addressing all health aspects. Our physical and behavioral health providers are integrated into this objective by inclusion in the member's multidisciplinary team (MDT). Additionally, Humana Healthy Horizons in Louisiana providers have access to training resources and evidence-based practice guidelines to facilitate collaboration and allow seamless coordination and continuity of member care.

~~to live a full, healthy and productive life. Through integration, our behavioral health program assists our members in achieving lifelong well-being and meeting their personal goals by addressing all health aspects. Our physical and behavioral health providers are integrated into this objective by inclusion in the member's multidisciplinary team (MDT). Additionally, Humana Healthy Horizons in Louisiana providers have access to training resources and evidence-based practice guidelines to facilitate collaboration and allow seamless coordination and continuity of member care.~~

Our objectives are consistent with the overall Humana Healthy Horizons in Louisiana mission and vision of becoming a world-class leader in helping people achieve lifelong well-being. Humana Healthy Horizons in Louisiana delivers person-centered, collaborative and comprehensive care management services that are supported by evidence-based care and integrated with other health services programs to facilitate improved member outcomes, enhanced member satisfaction, and optimal resource utilization. Ensuring a connection between our care management and Utilization Management UM teams is an integral part of this care.

~~management services that are supported by evidence-based care and integrated with other health services programs to facilitate improved member outcomes, enhanced member satisfaction, and optimal resource utilization. Ensuring a connection between our care management and UM teams is an integral part of this care.~~

Our Utilization Management UM program quickly evaluates and determines coverage for recommended services as well as provides needed assistance in facilitating appropriate use of resources and least restrictive settings of care to meet the member's behavioral health needs in a timely and effective manner. During this time, our care managers are involved with the member's care and are responsible for follow-up with the member during any transitions of care.

Goals of the behavioral health program

Our goal is to improve our member's sense of well-being, productivity and access to care, while educating and supporting an understanding and utilizing of benefits and resources.

Our integrated care management program is based on the philosophy of continuously improving the member's experience and quality of care, improving population outcomes and decreasing overall healthcare costs. Humana Healthy Horizons's Utilization ManagementUM, cCare mManagement, and pPopulation hHealth programs are integrated in our Model of Care. We work closely with the providers in our Humana Healthy Horizons in Louisiana network to ensure that these goals are met in a seamless manner, with our members receiving the full support of their various providers and the Humana Healthy Horizons in Louisiana support system.

Integration of behavioral health and medical care

Humana Healthy Horizons in Louisiana provides a comprehensive integrated care management model for our members at highest - risk membersrisk, including those with specialized behavioral health needs. Utilizing nurses and behavioral health licensed clinicians, including social workers and counselors, this multi-disciplinary approach combines practice standards to help members overcome healthcare access barriers. We also strengthen our provider and community resource partnerships by managing member care within a multi-disciplinary care team setting.

High-risk members often have multiple medical issues along with socioeconomic challenges and behavioral healthcare needs. The MDTs are led by experienced care managers who perform a comprehensive assessment that includes physical and behavioral health, socioeconomic needs, and social determinants of health, to develop an individualized, person-centered care plan. Members with specialized behavioral health needs (such as serious mental illness, substance use disorder (SUD) or severe emotional disturbance) are assigned to care managers trained in behavioral health. The care management team then sets an ongoing contact schedule to monitor outcomes and evaluate progress for possible updates to the care plan based upon member needs and preferences. Your patient's care plan is viewable by accessing the care coordination portal via Availity Essentials.com or requesting a copy by calling us at **1-800-448-3810 (TTY: 711)**.

Provider coordination for behavioral health

Network providers are required to coordinate care when members are experiencing behavioral health conditions that require ongoing care.

Primary care providers are required to:

- Provide basic behavioral health services to members, including:
  - Screening for mental health and substance use issues during routine and emergent visits
  - Prevention

- Early intervention
- Medication management
- Treatment and referral to specialized behavioral health services

- Follow up with behavioral health providers to coordinate integrated and unduplicated care.
- Obtain the necessary signed release for sharing ~~of personal health information~~PHI, including compliance with 42 CFR Part 2~~H~~ requirements around SUD.

Behavioral health providers are required to:

- Notify the PCP when a member initiates behavioral health services with the provider
- ~~Before sharing information with the PCP, O~~obtain a signed release for sharing ~~of personal health information~~PHI, in compliance with 42 CFR Part 2~~H~~ requirements around SUD, b~~.~~efore sharing information with the PCP
- Provide initial and quarterly summary reports to the PCP (after receiving the a~~forementioned~~~~bove~~ release of information)

Coordination with behavioral health care management

We recognize that members who experience complex behavioral health needs often have strong, established relationships with their care providers. Rather than disrupt these relationships with our own personnel, our care management program structure incorporates and supports existing member case management services provided by our network providers, state agencies or community-based organizations. This structure is enhanced through data~~- -~~sharing via our provider portal, our provider communication lines and participation in MDT meetings led by our care management team or provider-led case management team, based on member preference and need. Additionally, Humana Healthy Horizons ~~in Louisiana~~ is committed to coordinating with third-party member resources and will invite third-party c~~C~~are m~~M~~anagers to join a member's MDT, as appropriate and upon member request.

Continuity of care for behavioral health

For members receiving behavioral health inpatient hospital ~~inpatient behavioral health~~ services ~~at any level of care~~[FB124][DB125], Humana Healthy Horizons requires providers to schedule an outpatient follow-up appointment prior to the member's discharge from the facility. Your office can call p~~P~~rovider s~~S~~ervices at **1-800-448-3810 (TTY: 711)** for assistance with locating providers accepting new patients. The outpatient follow-up must be scheduled to occur within ~~seven~~ 7 days ~~from~~ of the date of discharge. Behavioral health providers are expected to contact patients within 24 hours of a missed appointment to reschedule.

Addiction[MMB126][DB127][MMB128]

~~The American Society of Addiction Medicine (~~ASAM~~)~~ defines addiction as a treatable, chronic medical disease impacted by brain circuitry, genetics, environmental factors and life experience. Dysfunction in the brain circuits leads to characteristic biological, psychological, social and spiritual manifestations.[1] This condition is reflected through pathological reward pursuit and/or relief by substance use and other behaviors.

Addiction is characterized by:

- An i~~l~~nability to ~~consistently~~ abstain consistently
- Impairment in behavioral control
- Craving~~,~~ or increased craving, for drugs or rewarding experiences
- Diminished recognition of significant problems with one's behaviors and interpersonal relationships
- A dysfunctional emotional response

The diagnosis of addiction requires a comprehensive biological, psychological, social and spiritual assessment by a trained and certified professional.

Addiction is more than a behavioral disorder. Features of addiction include aspects of a person's behaviors, cognitions, emotions and interactions with others, including a person's ability to relate to family or community members, ~~his or her~~their own psychological state~~,~~ and to things that transcend daily experience.

Successful prevention and treatment outcomes for addiction are similar to those for chronic medical diseases. L~~.~~ ~~L~~ike other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Recovery

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), recovery is a process of change through which people improve their health and wellness, live self-directed lives and strive to reach their full potential.[2] There are ~~four~~ 4 major dimensions that support recovery:

- **Health**—oOvercoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
- **Home**—hHaving a stable and safe place to live.
- **Purpose**—cConducting meaningful daily activities and having the independence, income, and resources to participate in society.
- **Community**—hHaving relationships and social networks that provide support, friendship, love, and hope.

Recovery-oriented care and support systems help people with addiction [MMB129][DB130][MG131]manage their conditions successfully. Hope—the belief that these challenges and conditions can be overcome—is the foundation of healing. Recovery is characterized by continual growth and improvement in one's health and wellness that may involve delays. Because setbacks are a natural part of life, resilience also is ~~also~~ important. Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress. Learning to bounce back can offer members the opportunity to improve their lives by maximizing potential and success.

Recovery support systems promote partnering with people in recovery from addiction to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms and achieve, as well as maintain, abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community.

Recovery services and supports must be flexible. Supporting recovery requires that addiction services:
- Be responsive and respectful to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups.
- Actively address diversity in the delivery of services.
- Seek to reduce health disparities in access and outcomes.

Treatment

There are many treatment options that have been successful in treating addiction, including:
- Behavioral counseling
- Medication
- Evaluation and treatment for co-occurring mental health issues such as depression and anxiety

Disclosures

Adherence to patient confidentiality laws is required of every Humana Healthy Horizons ~~in Louisiana~~ network provider. It is important for providers to be aware of these requirements and how they may be applied based on differing circumstances. For example, ~~the Health Care Portability and Accountability Act (~~HIPAA~~)~~ requires that providers only release ~~personal health information (~~PHI~~)~~ when permitted by law—such as when consent has been obtained or when it is necessitated by treatment or the payment of claims (42 CFR Part 2). An even more rigorous federal requirement designed for those receiving substance ~~ab~~use treatments almost exclusively prevents disclosures without the patient's consent.

Visit the following for m~~M~~ore information about HIPAA and 42 CFR Part 2 ~~can be at the following links~~:
- HIPAA: ~~-~~Centers for Medicare & Medicaid Services: HIPAA and administrative simplification ~~https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/PrivacyandSecurityInformation~~
- 42 CFR Part 2: ~~-~~SAMHSA: Substance use confidentiality regulations~~https://www.samhsa.go v/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs~~

Provider expectations regarding Office of Juvenile Justice ~~OJJ~~ and DCFS coordination

Coordinated system of care (CSoC)

The CSoC is designed to provide services and support~~s~~ to children and youth who have significant behavioral challenges or co-occurring disorders and are in, or at imminent risk of, out-of-home placement. The CSoC integrates resources from all of Louisiana's child-serving agencies, including ~~the~~ LDH, the Department of Education ~~(LDOE)~~, ~~Department of Children and Family Services (~~DCFS~~)~~ and the Office of Juvenile Justice ~~(OJJ)~~. Humana Healthy Horizons ~~in Louisiana~~ is committed to collaborating with the CSoC contractor and said agencies.

The family-driven and coordinated approach of CSoC is meant to create and oversee a service delivery system that is well integrated, has enhanced service offerings and achieves improved outcomes by ensuring families who have children with severe behavioral health challenges receive the right support and provider services with the proper intensity, timing and

length of time necessary to keep or return children to their home or home communities. Combining all services into one coordinated plan allows for invaluable communication and collaboration among families, youth, state agencies, providers and others who support the family.

~~and others who support the family.~~

CSoC qualifications:

- Behavior problems require the child to live elsewhere.
- The c~~C~~hild has attempted self-harm or tried to hurt ~~himself or~~ someone else.
- The c~~C~~hild is getting suspended and/or expelled from school.
- The c~~C~~hild has repeated run-ins with police.

If you think CSoC might be right for one of your patients, or you want more information, call 1-**800-448-3810** (TTY: 711).

Payment for services p~~P~~rovided to CSoC recipients

CSoC-eligible members receive physical health, ~~primary behavioral health and~~ pharmacy, and the following behavioral health services from Humana Healthy Horizons: Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), and Substance Use Disorder (SUD) Residential services (ASAM Levels 3.1, 3.2-WM, 3.3, 3.5, ~~and~~ 3.7 and 3.7-WM)[CC132][DB133]. All other behavioral health and CSoC services are covered by Prime Therapeutics.~~Magellan Healthcare~~[DB134]. ~~coverage from Humana Healthy Horizons.~~ ~~Specialized behavioral health services will be~~are ~~covered by Magellan Medicaid Administration~~[CC135][DB136]~~, except for Psychiatric Residential Treatment Facility (PRTFs), Therapeutic Group Home (TGHs), and SUD rResidential services (ASAM lLevels 3.1, 3.2-WMwm, 3.5 and 3.7).~~[CG137][DB138]

Humana Healthy Horizons ~~in Louisiana~~ is responsible for payment to enrolled providers for the provision of specialized behavioral health services for any month ~~during that~~in which the recipient has ~~a 1915(c)/1915(b)(3)~~ [CC139][DB140]segmentactive CSoC eligiblity ~~on the eligibility file~~ with a begin date later than the first day of that month. Humana Healthy Horizons is responsible for payment of ~~Psychiatric Residential Treatment Facility (~~PRTFs~~)~~, ~~Therapeutic Group Home (~~TGHs~~),~~ and SUD r~~R~~esidential services (ASAM l~~L~~evels 3.1, 3.2-WM~~wm~~, 3.3, 3.5 ~~and~~ 3.7 and 3.7-WM).[CG141] Providers [DB142]should submit [CC143][DB144]service claims for these recipients to Humana Healthy Horizons until the end of the month.[CC145][DB146]

Act 503

Act 503 revises the components of ~~Community Psychiatric Support and Treatment (~~CPST~~)~~ and ~~Psychosocial Rehabilitation Services (~~PSR~~)~~ and the staff able to provide these services. Per Act 503:

- ~~,~~ "~~c~~Community psychiatric support and treatment services" means CMS-approved Medicaid mental health rehabilitation services designed to reduce disability from mental illness, restore functional skills of daily living, build natural supports, and achieve identified person-centered goals or objectives through counseling, clinical psycho-education, and ongoing monitoring needs as set forth in an individualized treatment plan.
- "Psychosocial rehabilitation services" means CMS-approved Medicaid mental health rehabilitation services designed to assist the individual with compensating for or eliminating functional deficits and interpersonal or environmental barriers associated with mental illness through skill building and supportive interventions to restore and rehabilitate social and interpersonal skills and daily living skills.
- Any individual rendering the assessment and treatment planning components of CPST and PSR [CC147][DB148]services for a licensed and accredited provider agency shall be a fully licensed mental health professional.
- Any individual rendering any of the other components of CPST services for a licensed and accredited provider agency shall be a fully licensed mental health professional, a provisionally licensed professional counselor, a provisionally licensed marriage and family therapist, a licensed master social worker, a certified social worker~~,~~ or a psychology intern from an ~~American Psychological Association~~APA ~~-~~approved internship program.
- Any individual rendering PSR services for a licensed and accredited provider agency shall hold a minimum of one of the following: a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, criminal justice~~,~~ or human growth and development~~.~~ or have a bachelor's degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology; or be 21 years of age or older as of January 1, 2022, have a high school diploma or equivalency, and have been continuously employed by a licensed and accredited agency providing PSR services since prior to January 1, 2019 [CC149].[CC150][DB151]

Individuals providing services[CC152][DB153]

Services must be provided in accordance with the requirements of the LDH Behavioral Health Services Manual (BHSM). The BHSM describes the practice requirements and can be found at the following link: BHS_Provider_Manual.pdf. ~~BHS_Provider_Manual.pdf (la.gov)~~

Humana Healthy Horizons will periodically inform providers of updates to the BHSM through provider website and Availity

notifications.

To be eligible to receive Medicaid reimbursement, BHSPs must ensure that any providers rendering CPST or PSR or CPST services for their agency meets all the following requirements:

- Have a National Provider Identification numberAn (NPI is required). The individual rendering the PSR or CPST services for the licensed and accredited provider agency must have an individual NPI number, and that number must be included on any PSR or CPST claim submitted by that provider agency for Medicaid reimbursement (in addition to the agency NPI number).
- Any individual rendering the assessment and treatment planning components of CPST services for a licensed and accredited provider agency shall be a fully licensed mental health professional.
- Any individual rendering any of the other components of CPST services for a licensed and accredited provider agency shall be a fully licensed mental health professional, a provisionally licensed professional counselor, a provisionally licensed marriage and family therapist, a licensed master social worker, a certified social worker, or a psychology intern from an American Psychological AssociationAPA- approved internship program.
- Any individual rendering PSR services for a licensed and accredited provider agency shall hold: a minimum of one of the following: a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, criminal justice, or human growth and development.

Detailed information about these requirements can be found in the Louisiana Medicaid Behavioral Health Services Provider Manual accessible via LAMedicaid.com. Please review thoroughly to ensure that you are complying with these new requirements.

Provider quality monitoring program for specialized behavioral health providers

Humana Healthy Horizons in Louisiana monitors specialized behavioral health providers and facilities across all levels of care, incorporating desktop and onsite audits, onsite audits, and member interviews, with a focus on unlicensed providers delivering care. Humana Healthy Horizons conducts quality reviews are conducting using a sample of providers' client records on a quarterly basis. Providers are required to adhere to minimum provider qualifications and requirements at the organizational level and the individual staff level as established by Louisiana law, rules, regulations, state plan, waivers, the Louisiana Medicaid Behavioral Health Services Provider Manual, and other governing bodies. This includes, but is not limited to, requirements associated with licensure, accreditation, educational and professional experience, and training inclusive of utilization of LDH-approved training curriculum in the delivery of services, if applicable, as established by the Louisiana Medicaid Behavioral Health Services Provider Manual. Provider quality monitoring verification includes a review of behavioral health treatment records review. Treatment records are expected to include all elements as outlined in the current copy of the Louisiana Medicaid Behavioral Health Services Provider Manual, which is available at https://www.lamedicaid.com/provweb1/Louisiana Medicaid Behavioral Health Services Provider Manualprovidermanuals/BHS_main.htm.The Provider Quality Monitoring Review criteria will include the following, but is not limited to:

- adherence to clinical practice guidelines
- adherence to agency specific clinical documentation requirements
- enrollee rights and confidentiality, including advance directives and informed consents
- cultural competency and ;patient safety including adverse incident management/reporting
- appropriate use of restraints and seclusions
- treatment planning components (evaluates if the assessment and treatment are conducted timely and include member participation, the quality of the assessment and treatment plan, whether members are receiving services as reflected in the treatment/service plan)
- adequate discharge planning, as applicable and care coordination

~~with licensure, accreditation, educational and professional experience, and training inclusive of utilization of LDH-approved training curriculum in the delivery of services, if applicable, as established by the Medicaid Behavioral Health Services Provider Manual. Provider quality monitoring verification includes review of behavioral health treatment record review. Treatment records are expected to include all elements as outlined in the current copy of the Louisiana Medicaid Behavioral Health Services Provider Manual, which is available at https://www.lamedicaid.com/provweb1/providermanuals/BHS_main.htm.~~

Humana Healthy Horizons ~~in Louisiana~~ initiates the appropriate corrective action when a provider or staff member fails to meet quality standards and requirements, minimum provider qualifications or requirements, or appointment availability standards, or is found to be out of compliance with contract provisions, federal and state regulations, laws, rules, the state plan amendment (SPA), waivers, the Louisiana Medicaid Behavioral Health Services Provider Manual or the managed care manual. Humana Healthy Horizons ~~in Louisiana~~ monitors and evaluates corrective actions taken to ensure ~~that~~ appropriate changes have been made in a timely manner.

Providers are expected to meet performance requirements and ensure member treatment is efficient and effective. Providers are expected to monitor and evaluate their own compliance with performance requirements to assure delivery of quality care.

Providers should:

- Cooperate with medical record reviews and reviews of telephone and appointment accessibility~~.~~
- Cooperate with our complaint review process~~.~~
- Participate in provider satisfaction surveys~~.~~
- Cooperate with reviews of quality-of-care issues and critical incident reporting~~.~~

- In addition, providers are invited to participate in our quality improvement committees and in local focus groups.

Applied bBehavioral aAnalysis (ABA) qQuality mM~~M~~onitoring r~~R~~eview

Humana Healthy Horizons ~~in Louisiana~~ monitors specialized ABA providers and facilities across all levels of care, which incorporates onsite and desktop reviews ~~and desktop reviews~~. Providers are required to adhere to minimum provider qualifications and requirements at the organizational level and the individual staff level as established by Louisiana law, rules, regulations, ~~state plan~~the SPA, waivers, the Louisiana Medicaid Behavioral Health Services Provider Manual~~,~~ and other governing bodies. ABA ~~This includes, but is not limited to, requirements associated with licensure, accreditation, educational and professional experience, and training inclusive of utilization of LDH-approved training curriculum in the delivery of services, if applicable, as established by the Louisiana Medicaid Applied Behavioral Analysis Services Provider Manual.~~ Provider quality monitoring verification includes a review of ABA treatment record~~s review~~. ~~ABA.pdf (lamedicaid.com) https://www.lamedicaid.com/provweb1/ Provider manuals/manuals/ABA/ABA.pdf~~

~~Humana Healthy Horizons' in Louisiana's plan complies with all the requirements:~~

- ~~Review criteria for each applicable provider type/level of care;~~
- ~~Sampling approach including number and percentage of onsite surveys by provider type, number and percentage of desktop reviews, and number of charts to be reviewed at each provider location;~~
- ~~Random criteria;~~
- ~~Tools to be used;~~
- ~~Frequency of review, including schedule of reviews by provider type;~~
- ~~Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis; and~~
- ~~Plan for ensuring corrective actions is implemented appropriately and timely by providers.~~

Humana Healthy Horizons' ~~in Louisiana's~~ review criteria shall address the following areas, at a minimum:

- Quality of care consistent with professionally recognized standards of practice
- General r~~R~~ecord e~~E~~lements
- Member rights and c~~C~~onfidentiality
- Comprehensive d~~D~~iagnostic e~~E~~valuation
- Prescription/r~~R~~eferral for ABA therapy
- Record of qualifying diagnosis
- Treatment p~~P~~lan
- Progress n~~N~~otes
- Continuity and c~~C~~oordination of c~~C~~are

- Patient ss~~S~~afety

- Cultural cCompetency
- Adverse incidents
- Discharge pPlanning

~~Humana Healthy Horizons in Louisiana initiates the appropriate corrective action when a provider or staff~~ member ~~fails to meet quality standards and requirements, minimum provider qualifications or requirements,~~ or ~~appointment availability standards, or is found to be out of compliance with contract provisions, federal and state regulations, laws, rules, state plan amendment (the SPA), waivers, the~~ Louisiana ~~Medicaid Behavioral Health Services Provider Manual or~~ the ~~managed care manual.~~

~~Humana Healthy Horizons in Louisiana monitors and evaluates corrective actions taken to ensure that appropriate changes have been made in a timely manner. Providers are expected to meet performance requirements and ensure member treatment is efficient and effective. Providers are expected to monitor and evaluate their own compliance with performance requirements to assure delivery of quality care.~~

~~Providers should:~~

- ~~Cooperate with record reviews and reviews of telephone and appointment accessibility.~~
- ~~Cooperate with our complaint review process.~~
- ~~Participate in provider satisfaction surveys.~~
- ~~Cooperate with reviews of quality-of-care issues and critical incident reporting.~~
- ~~In addition, providers are invited to participate in our quality improvement committees and in local focus groups.~~

Provider network monitoring

Humana Healthy Horizons ~~in Louisiana~~ provider network review monitors specialized behavioral health providers and facilities across all levels of care, incorporating desktop and ~~audits and~~ onsite audits. Humana Healthy Horizons ~~in Louisiana~~ conducts provider network monitoring reviews ~~are conducting~~ using a sample of provider and staff personnel records and other administrative records on a quarterly basis. Providers are required to adhere to minimum provider qualifications and requirements at the organizational level and the individual staff level as established by Louisiana law, rules, regulations, the SPA~~state plan~~, waivers, the Louisiana Medicaid Behavioral Health Services Provider Manual~~,~~ and other governing bodies. This includes, but is not limited to, requirements associated with licensure, accreditation, educational and professional experience, and training inclusive of utilization of LDH-approved training curriculum in the delivery of services, if applicable, as established by the Louisiana Medicaid Behavioral Health Services Provider Manual. ~~Provider and staff personnel records and other administrative records are expected to include all elements as outlined in the current copy of the Louisiana Medicaid Behavioral Health Services Provider Manual., which is available at https://www.lamedicaid.com/provweb1/providermanuals/BHS_main.htm.~~

~~requirements associated with licensure, accreditation, educational and professional experience, and training inclusive of utilization of LDH-approved training curriculum in the delivery of services, if applicable, as established by the Medicaid Behavioral Health Services Provider Manual. Provider and staff personnel records and other administrative records are expected to include all elements as outlined in the current copy of the Louisiana Medicaid Behavioral Health Services Provider Manual, which is available at https://www.lamedicaid.com/provweb1/providermanuals/BHS_main.htm.~~

Humana Healthy Horizons ~~in Louisiana~~ initiates the appropriate corrective action when a provider or staff member fails to meet quality standards and requirements, minimum provider qualifications or requirements, or appointment availability standards, or is found to be out of compliance with contract provisions, federal and state regulations, laws, rules, ~~state~~ the ~~plan amendment (~~SPA~~)~~, waivers, the Louisiana Medicaid Behavioral Health Services Provider Manual or the managed care manual.

Humana Healthy Horizons ~~in Louisiana~~ monitors and evaluates corrective actions taken to ensure ~~that~~ appropriate changes have been made in a timely manner. Providers are expected to meet performance requirements and ensure member treatment is efficient and effective. Providers are expected to monitor and evaluate their own compliance with performance requirements to assure delivery of quality care. Providers must meet licensure and/or certification requirements, as well as other additional requirements, as outlined in the Louisiana Medicaid Behavioral Health Services Provider Manual, determined by their level of care.

Behavioral Health Fidelity Monitoring Plan for evidence-based programs

Evidence-based practice (EBP) models contain a combination of clinical expertise, patient values and evidence research. Fidelity monitoring is an evaluation of the program design and the accurate delivery of intended consistent program interventions. ~~Evidence-based practice~~EBP programs operating with high fidelity produce positive consumer outcomes.

Ongoing fidelity monitoring allows Humana Healthy Horizons to attribute consumer outcomes to interventions. Humana Healthy Horizons's Behavioral Health Fidelity Monitoring Plan monitors the following:

- ~~Assertive Community Treatment (~~ACT~~)~~
- ~~Eye Movement Desensitization and Reprocessing Therapy (~~EMDR~~)~~
- ~~Family functional therapy (~~FFT~~)~~
- ~~Functional Therapy – Child Welfare (~~FFT-CW~~)~~
- Homebuilders
- ~~Multi-systemic therapy (~~MST~~)~~
- ~~Individualized Placement and Support (IPS)[AD154][DB155]~~IPS

- ~~Child Parent psychotherapy (~~CPP~~)~~
- ~~Parent child interactive therapy (~~PCIT~~)~~
- ~~Preschool and youth post-traumatic stress disorder (PTSD~~PPT and YPT~~)~~
- Tripe P P~~P~~ositive Parenting Program ~~Standard Level 4 (Triple P L4)~~
- Trauma-focused cognitive behavioral therapy (TF-CBT)
- Other programs as identified by LDH

The Fidelity Monitoring Plan assesses for program readiness; establishes a baseline status for new providers and program implementation; creates an action plan; provides provider consultation and training~~,~~ as needed; and continually monitors program-level implementation/processes and participant interventions. Fidelity monitoring is completed by vendors that represent the interests of Humana Healthy Horizons.~~The Ffidelity Mmonitoring Pplan will assesses for program readiness, establish baseline status for new providers, program implementation and create an action plan if needed, provider consultation and training as needed and ongoing monitoring of program-level implementation/processes and participant interventions. Fidelity monitoring is completed by vendors that represents the interest of Humana.~~

Chapter 10~~HAPTER X~~: Member enrollment and eligibility ~~EMBER ENROLLMENT AND ELIGIBILITY~~

Medicaid eligibility

Medicaid eligibility is determined by the ~~Louisiana Department of Health (~~LDH~~)~~ in the member's county of residence.

LDH provides eligibility information to Humana Healthy Horizons daily via an 834 file for members assigned to Humana Healthy Horizons ~~in Louisiana~~. Eligibility begins on the first day of each calendar month for members joining Humana Healthy Horizons ~~in Louisiana~~, except for babies born to an eligible mother.

Newborn enrollment

Humana Healthy Horizons ~~in Louisiana~~ begins coverage of newborns on the date of birth, up to a minimum of ~~one (~~1~~)~~ month, when the newborn's mother is a member of the Humana Healthy Horizons ~~in Louisiana~~ plan. The mother ~~does~~ has the option of choosing another MCO for her baby, following the birth. If the mother chooses a different MCO for the baby, enrollment in the new MCO will be effective the first day of the month after she chooses the new MCO if the choice is made on or before the second to last working day of the month. The newborn will appear on the chosen PCP's member eligibility list after the baby ~~it~~ is added to the Humana Healthy Horizons ~~in Louisiana~~ system. If a PCP for the newborn is not chosen during the hospital stay, Humana Healthy Horizon ~~in Louisiana~~ provides a minimum of 14 calendar days for one to be chosen for the ~~enrollee~~member before one is auto assigned.

You can verify eligibility for a newborn on the Availity Essentials~~Availity Essentials~~ p~~P~~rovider p~~P~~ortal ~~at Availity.com~~.

Hospitals are required to report all births, within 24 hours of birth, via the LDH s~~S~~elf-s~~S~~ervice p~~P~~rovider p~~P~~ortal. Hospitals also are ~~also~~ required to register births through the Louisiana Electronic Event Registration System (LEERS), administered by LDH/ Vital Records Registry, within 15 calendar days of birth. Within ~~three (~~3~~)~~ business days, LDH will assign the newborn a Medicaid ID and add the baby to the Medicaid eligibility file.~~-~~

New member kits

Each new member household receives a new member kit (including a welcome letter) and an ID card for each person in the family who has joined Humana Healthy Horizons ~~in Louisiana~~. New member kits are mailed separately from the member ID card.

The new member kit contains:

- A w~~W~~elcome letter
- Information on how to obtain a copy of the Humana Healthy Horizons provider directory
- A member newsletter, which explains how to access plan services and benefits, including the member handbook

- A health needs assessment survey
- Continuity of care form

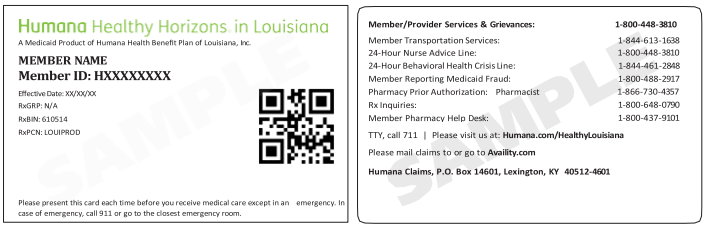
Member ID cards[DB156]

All new Humana Healthy Horizons ~~in Louisiana~~ members receive a~~n~~ member ID card. A new card is issued only when the information on the card changes or i~~,~~ if a member loses a card or ~~if an member~~ requests an additional card. Eligible members will receive a state Medicaid card and a Humana Healthy Horizons ~~in Louisiana~~ ID card; both must be presented at regular and follow-up provider appointments.

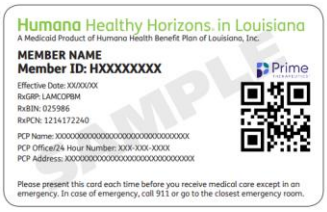
The member ID card is used to identify a Humana Healthy Horizons ~~in Louisiana~~ member; it does not guarantee eligibility or benefits coverage. Members may disenroll from Humana Healthy Horizons ~~in Louisiana~~ and retain their previous ID card. Likewise, members may lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to every service.

2024 Louisiana A Medicaid English cCard

2024 Louisiana Medicaid A behavioral health BH English cCard[DB157]



2025 Louisiana Medicaid English card



2025 Louisiana Medicaid behavioral health English card

Important things to know about the information provided on each member's Humana Healthy Horizons in Louisiana ID card:

FrontRONT:	BackACK:
Humana Healthy Horizons in Louisiana mMember ID: Use this number on claims	Behavioral Health Hotline: Members can call this hotline 24/7/365 for mental health or addiction services.
PCP nName/pPhone: Each mMembers chooses a participating provider to be his or hertheir primary care providerPCP. If no choice is made, Humana Healthy Horizons in Louisiana assigns a PCP.	Provider pPortal: Our website contains plan information and access to special functionality, such as eligibility verification, claim and prior authorization submission, COB checks and more.

Automatic primary care physician (PCP) assignment

A PCP will be assigned automatically to members who have not chosen a PCP or who are passively enrolled in Humana Healthy Horizons in Louisiana coverage. Humana Healthy Horizons' in Louisiana's internal system can identify a member's previous PCPs within Humana Healthy Horizons's participating PCP panel and assist through auto assignment (if applicable). Geographic assignment by distance will be used when a member has no record of past PCP relationships within the participating Humana Healthy Horizons in Louisiana PCP panel. Humana Healthy Horizons' in Louisiana's internal editing system also ensures that the auto assigned PCP is age-appropriate for the member (i.e., pediatricians will be assigned to pediatric members and adults assigned to a PCP who specializes in the treatment of adults). Newborn members have up to 14 days for PCP assignment once received on the 834 enrollment file.

Monitoring PCP reassignment

Humana Healthy Horizons in Louisiana will conduct periodic monthly analytical reviews of PCP membership assignments to ensure members are appropriately paneled. Humana Healthy Horizons provider panel reports (file name: REMBX) will be generated between the 25th and 28thon the 15th of each month; panel reports and the results of the analytical output of our claims-based attribution model will be shared with the PCP via Availity Essentials. The PCPs will be given fifteen (15) business days to dispute any member currently on their panel or the outcome of the claims-based attribution analysis with the market. The provider will submit a dispute form and supporting information to LAPEAttributionDispute@hHumana.com. Humana Healthy Horizons in Louisiana will review and the determination will be communicated to the provider within fifteen (15) calendar days of receipt of the dispute.

with the PCP via Availity. The PCP will be given fifteen (15) days to dispute any member currently on their panel or the outcome of the claims-based attribution analysis with the market. The provider will submit a dispute form and supporting information to LAPEAttributionDispute@Humana.com. Humana Healthy Horizons in Louisiana will review and the determination will be communicated to the provider within fifteen (15) calendar days of receipt of the dispute.

Disenrollment

Humana Healthy Horizons ~~in Louisiana~~, LDH or the member can initiate disenrollment. Members may disenroll from Humana Healthy Horizons ~~in Louisiana~~ for a number of reasons, including:

- Voluntary disenrollment within 90 days of initial enrollment with ~~the MCO~~Humana Healthy Horizons
- ~~MCO~~ Humana Healthy Horizons doesn't cover services requested by the member because of moral or religious objections
- Lack of access to ~~MCO~~Humana Healthy Horizons-covered services as determined by LDH

Humana Healthy Horizons ~~in Louisiana~~ can initiate member disenrollment for the following reasons:

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to provide services to the member or others

Please notify the Humana Healthy Horizons ~~in Louisiana~~ Care Management d~~D~~epartment at 1~~-~~**800-448-3810 (TTY: 711)** if one or all of the situations listed above occur. Please see the section below for procedures for dismissing noncompliant members from your practice. We can counsel the member or, in severe cases, initiate a request to LDH for disenrollment. LDH will review each disenrollment request and determine if the request should be granted. LDH provides disenrollment information to Humana Healthy Horizons ~~in Louisiana~~ daily via the 834 file for members assigned to Humana Healthy Horizons ~~in Louisiana~~. Disenrollment from Humana Healthy Horizons ~~in Louisiana~~ always will occur at the end of the effective month.

If members lose Medicaid eligibility, they also lose eligibility for Humana Healthy Horizons ~~in Louisiana~~ benefits.

Automatic renewal

If Humana members lose Medicaid eligibility~~,~~ but become eligible again within ~~60 days the year~~60 days, they are automatically re-enrolled in Humana Healthy Horizons ~~in Louisiana~~ and assigned to the same PCP, if possible. Please call p~~P~~rovider s~~S~~ervices at 1-**800--448-3810** (TTY: 711) if you have questions about disenrollment reasons or procedures.

Referrals for release due to ethical reasons

Humana Healthy Horizons ~~in Louisiana~~ providers are not required to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 45 C~~.~~F~~.~~R~~.~~ 88.

The provider must refer the member to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition. The referred-to provider must be actively enrolled with the state to provide Medicaid services to beneficiaries and be in Humana Healthy Horizons' ~~in Louisiana's~~ provider network.

When ~~a~~ providers feel~~s~~ that ~~his/her~~their conscience, religious beliefs~~,~~ or ethical principles require involuntary dismissal of ~~the~~ a member as ~~his/her~~their patient, the provider's office must notify the member of the dismissal by certified letter.

The letter should include:

- The reasoning behind the dismissal request
- Referral to another provider licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition
  - ~~.(~~The provider must be actively enrolled with the state of Louisiana to provide Medicaid services to beneficiaries and must be in Humana Healthy Horizons in Louisiana's provider network.~~)~~
- Instructions to call Humana Healthy Horizons' ~~in Louisiana~~ member services at 1-**800-448-3810** (TTY: 711)~~-~~ for assistance in finding a preferred in--network provider.

A copy of the letter must be sent or faxed to Humana at the following address:

Mail:
Humana
Attn: Service Operations Resolution Team (SORT)
P.O. Box 221529
Louisville, KY 40252-1529

Fax: 937-226-6916

Member support services benefits

Humana Healthy Horizons ~~in Louisiana~~ offers a variety of educational services, benefits and support to our members to facilitate their use and understanding of our services, promote preventive healthcare and encourage appropriate use of those services. We are always happy to work with you to meet the healthcare needs of our members.

Member services

Humana Healthy Horizons ~~in Louisiana~~ can assist members who have questions or concerns about benefits and services such as case or disease management.

Representatives are available by telephone at

1-**800-448-3810** (TTY: 711), Monday through Friday, 7 a.m. to 7 p.m. ~~Central time~~, except on Humana-observed holidays. If the holiday falls on a Saturday, we will be closed the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

24-hour n~~N~~urse a~~A~~dvice l~~L~~ine

Members can ask an experienced staff of registered nurses about health-related symptoms 7~~seven~~ days a week, 365 days a year, by calling 1-**800-448-3810** (TTY: 711). ~~**800-448-3810**.~~

The nurses educate members about the benefits of preventive care. ~~and make referrals to our disease and case management programs. They also promote the PCP-member relationship by explaining the importance of the PCP in coordinating the member's care.~~

Key features of this service include:

- Access to a Nurse available to answer health-related questions via telephone, systematic assessment of symptoms, and recommendations for the most appropriate treatment, clinical resources and care setting (e.g., home,

virtual consultation, retail clinic, ~~doctor's~~provider's office, urgent care facility, ER, etc.)~~.~~
  - Urgent and non-urgent care advice
  - Health and wellness education, reminders and resources
  - Condition, procedure and treatment explanations
  - Medication information, including drug interactions, appropriate use, and adherence benefits and strategies

~~• Assessment of member symptoms~~

- Professional advice offered regarding the appropriate level of care
- Helpful answers to health-related questions and concerns
- Referral information about other services
- Encouragement of the PCP–member relationship

The nurses assess member symptoms using the Schmitt-Thompson Clinical nurse triage guidelines to offer evidence-based triage protocols and decision support. The well-regarded system is used by thousands of health systems, clinics, and physician practices.

Emergency behavioral health services

For behavioral health services, members should call a contracted behavioral healthcare provider in their area. The provider can give the member a list of common behavioral problems and advise how to recognize any symptoms. For assistance in finding a provider, members may call Humana Healthy Horizons' member services at 1-800-448-3810 **(TTY: 711)**, Monday through Friday, 7 a.m. to 7 p.m., Central time, except on Humana-observed holidays. Members may call Humana''s mMember sServices toll-free number at **1-800-448-3810** to get help in finding a provider. Hours of Operation for the Humana Healthy Horizon in Louisiana are Monday through Friday, 7 a.m. to 7 p.m. Central time, except on Humana-observed holidays. If the holiday falls on a Saturday, we will be closed the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

24-hour bBehavioral hHealth cCrisis hHotline

For emergency behavioral healthcare within or outside the service area, please instruct members to call either call their bBehavioral hHealth sService pProvider (who maintains the member's Crisis Mitigation Plan and provides 24-hour on-call telephone assistance to prevent relapse or harm to self or others, referral to other services, and support during crises) or to report to the closest hospital emergency room (ER) or any other recommended emergency setting. They should contact you or Humana Healthy Horizons's 24-hour Behavioral Health Crisis Line first if they are not sure the problem is an emergency. Humana Healthy Horizons' in Louisiana's 24-hour Behavioral Health Crisis Hotline is staffed by trained personnel 24 hours a day, seven 7 days a week, year-round. Crisis hotline staff includes qualified behavioral health services professionals who can assess, triage and address specific behavioral health emergencies at 1-**844-461-2848**.

Emergency mental health conditions include:

- Those that create a danger to the member or others
- Those that render the member unable to carry out actions of daily life due to functional harm
- Those resulting in serious bodily harm that may cause death

Chapter 11HAPTER XI: Member rights and responsibilitiesEMBER RIGHTS AND RESPONSIBILITIES

As a Humana Healthy Horizons in Louisiana provider, you are required to respect the rights of our members. Humana Healthy Horizons in Louisiana members are informed of their rights and responsibilities via the member handbook. The A list of our member's rights and responsibilities is below.

All members are encouraged to take an active and participatory role in their own health and the health of their family. Each member is guaranteed the following rights:

- To receive information in accordance with federal regulations as described in the contract and department-issued guides.
- To receive information about the organization, its services, its practitioners, and providers and member rights and responsibilities.
- To receive courteous, considerate and respectful treatment provided with due consideration for the member's dignity and privacy.
- To have a candid discussion of appropriate or medically necessary treatment options and alternatives in a manner appropriate to member's condition and ability to understand, regardless of cost or benefit coverage.
- To participate in treatment decisions, including the right to:
  - Refuse treatment
  - Have cComplete information access regarding the member's specific condition and treatment options regardless of cost or benefit coverage including, but not limited to:
    - The right to receive services in a home or community setting or institutional setting if desired

- Seek second opinions
- Receive information about available experimental treatments and clinical trials and how such research can be accessed~~; and~~
- Receive a~~A~~ssistance with care coordination from the PCP's office
- Be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience~~.~~

- To be able to e~~E~~xpress a concern about the member's MCO or the care it provides, or appeal an MCO decision, and receive a response in a reasonable period of time~~.~~
- To r~~R~~eceive a copy of member medical records, including, if the HIPAA privacy rule applies, the right to request that the

records be amended or corrected as allowed in federal regulations.

- To bBe furnished with health-care services in federal regulations governing access standards.
- To be able to cComplete an advance directive, as required in federal regulations
  - .The MCO must provide adult members with written information on advanced directive policies and include a description of applicable state law. The written information must reflect any changes in state law as soon as possible, but no later than 90 days after the effective date of change.
- Members have the rightTo be able to file a grievance to LDH or other appropriate licensing or certification agency as allowed in federal regulations regarding noncompliance with the advance directive requirements.
- Members canTo be able to choose health professionals to the extent possible and appropriate under federal regulations
- To be able to rRequest a practitioner of the same race, ethnicity and/or language if there is a practitioner available in the member'sir network
- To receive health-care services in accordance with all other applicable federal regulations
- To exercise the rights described herein without any adverse effect on member treatment by LDH, the MCO or its contractors or providers
- To make recommendations to the mMember rRights and rResponsibilities statement

Member responsibilities shall include, but are not limited to:

- Informing the MCO of the loss or theft of a member's MCO identification ID card
- Presentationg of the member identification ID card when using health-care services
- Protectiong of the member ID card and understanding that misuse of the card, including loaning, selling or giving it to others, could result in loss of Medicaid eligibility and/or legal action
- Being fFamiliarity with the MCO's policies and procedures
- Contacting the MCO, by telephone or in writing (formal letter or electronically, including email), to obtain information and have questions clarified
- Providinge the information Humana Healthy Horizons and your healthcare providers need in order to care for you
- Following the advice and instructions for care they membershave agreed upon with their doctors and other healthcare providers
- Understanding their health problems, participating in developing treatment goals and following the provider--prescribed treatment of care or explaining as soon as possible why the treatment cannot be followed
- Making every effort to keep all agreed-upon appointments and contacting the provider in advance if unable to do so
- Accessing preventive care services
- Notifying Humana Healthy Horizons immediately if the member has a wWorkers' cCompensation claim, a pending personal injury or a medical malpractice lawsuit, or if the member is if involved in an auto accident.
- Reporting any changes in family size, living arrangements, parish of residence or mailing address to the LDH at: Phone: 1-**888-342-6207**, Monday through Friday,
- 7 a.m. to 4:30 p.m. Central time
  Website:
  sspweb.lameds.ldh.la.gov/selfservice/LDH
  Local offices:
  LDH Medicaid
  directoryldh.la.gov/index.cfm/directory/category/158

Personally identifiable information (PII) and protected health information (protected health informationPHI)

In the day-to-day business of patient treatment, payment and healthcare operations, Humana Healthy Horizons and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide how PII is appropriately protected when stored, processed and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your patients' data.

You also are mandated by HIPAA to secure all PHI related to your patients. There are many administrative, physical and technical controls you should have in place to protect all PII and PHI.

Here are some important places to start:

- Use a secure message tool or service to protect data sent by email.

- Have policies and procedures in place to protect paper documents containing patient information, including ~~secure~~ storage, handling and destruction of documents
- Encrypt all laptops, desktops and portable media such as CD-ROMs and USB flash drives that may contain PHI or PII.

Member privacy

~~The~~ HIPAA p~~P~~rivacy r~~R~~ule~~s~~ require~~s~~ health plans and covered healthcare practitioners to develop and distribute a notice that provides a clear, user-friendly explanation of individuals' rights with respect to their personal health information, as well as the privacy practices of health insurance plans and healthcare practitioners.

~~The~~ LDH provides a privacy notice to Medicaid members. Access the HIPAA ~~i~~nformation page ~~is~~ at LDH HIPAA policies and forms~~ldh.la.gov/index.cfm/ page/131.~~. The notice informs members ~~about~~ of how ~~the~~ LDH is legally required to protect the privacy of member data.

As a provider, please follow HIPAA regulations and make only reasonable and appropriate uses and disclosures of ~~protected health information~~PHI for treatment, payment and healthcare operations.

Member consent to share health information

Obtaining a member's written permission to share patient information is defined as securing consent. Not all disclosures require the member's permission.

The following are consent requirements that pertain to sensitive health information (SHI) and ~~substance-use disorder (~~SUD~~)~~ treatment:

- SHI is defined by the state (e.g., relating to H~~H~~IV/AIDS, mental health, sexually transmitted diseases).
- SUD 42 CFR Part 2 ~~(Part 2)~~ pertains to federal requirements that apply to all states.

While all member data is protected under ~~the~~ HIPAA p~~P~~rivacy r~~R~~ules, Part 2 provides more stringent federal protections in an attempt to protect individuals with ~~substance-use disorders~~SUDs who could be subject to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protections for the sharing of certain information determined to be SHI.

When consent is on record, Humana Healthy Horizons ~~in Louisiana~~ will display all member information on the provider portal at Availity Essentials~~.com~~ and any health information exchanges. Please explain to your patients that if they do not consent to let Humana Healthy Horizons share this information, the providers involved in their care may not be able to effectively coordinate their care. When a member does not consent to share this information, a message displays on the provider portal to indicate that all of the member's health information may not be available to all providers.

~~does not consent to share this information, a message displays on the provider portal to indicate that all of the member's health information may not be available to all providers.~~

The Member Consent/HIPAA Authorization Form also can be used to designate a person to speak on the member's behalf. This designated representative can be a ~~physician~~provider, an attorney, a relative or some other person the member specifies.

LDH requirements regarding 24/7 PCP coverage

The referring PCP is responsible for arranging for coverage of services, consultation or approval for referrals by Medicaid~~-~~-enrolled providers who ~~will~~ accept Medicaid reimbursement. This referred coverage shall consist of an answering service, call forwarding feature, provider call coverage or other customary means approved by LDH. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-~~-~~hours coverage must be accessible using the medical office's daytime telephone number. The PCP arranges for coverage of primary care services during absences due to vacation, illness or other situations in which the PCP is unable to provide services. A Medicaid-eligible PCP must provide coverage.

For the best interest of our members and to promote their positive healthcare outcomes, Humana Healthy Horizons ~~in Louisiana~~ supports and encourages continuity of care and coordination of care between medical providers as well as between medical providers and behavioral health providers.

Americans with Disabilities Act (ADA)

All Humana Healthy Horizons ~~in Louisiana~~ -contracted healthcare providers must comply with the federal ~~Americans with Disabilities Act (~~ADA~~)~~, as well as all applicable state and/or federal laws, rules and regulations. More details are available in the Humana Healthy Horizons in Louisiana provider agreement under "Compliance with Regulatory Requirements."

Humana Healthy Horizons in Louisiana develops individualized care plans that take into account members' special and unique needs. Healthcare providers with patients who require interpretive services can call 1-**877-320-1235** or email accessibility@humana.com with date, time, provider phone number and location for appointment. Please do not include any patient health information. This is not needed when emailing.

Members who need interpretation services can call the number on the back of their member ID card or visit Humana's website at Humana.com/accessibility-resources.

Cultural competency

Participating providers are expected to provide services in a culturally competent manner ~~which~~ that includes, but is not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient.

Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they

pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the ~~Americans with Disabilities Act~~ADA and the Rehabilitation Act of 1973.

Humana Healthy Horizons ~~in Louisiana~~ recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. ~~It is~~We are committed to developing strategies that eliminate health disparities and address gaps in care.

A workshop supported by the National Institutes of Health and the Agency for Healthcare Research and Quality in 2023 found that a "health workforce that reflects the national cultural and language diversity and the lived experiences and cultural context of the communities that it serves is necessary to advance equity."[3] ~~A report by the Institute of Medicine (now called the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine) in 2002 confirmed the existence of racial and ethnic disparities in healthcare. The report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," found racial differences in the type of care delivered across a wide range of healthcare settings and disease conditions, even when controlling for socioeconomic status factors such as income and insurance coverage. Annual national healthcare disparity reports from the Agency for Healthcare Research and Quality (AHRQ) confirm that these gaps persist in the American healthcare system.~~

~~socioeconomic status factors such as income and insurance coverage. Annual national healthcare disparity reports from the Agency for Healthcare Research and Quality (AHRQ) confirm that these gaps persist in the American healthcare system.~~

Communication is crucial to delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers. Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine healthcare-seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and improvements in communication with a growing number of diverse patients.

Humana Healthy Horizons offers a number of initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources. To request assistance with non-English languages for patients, please call **1-877-320-2233** or email

accessibility@humana.com and a Humana Concierge Service for Accessibility representative will contact you to set up service for Humana Healthy Horizons ~~in Louisiana~~ patients. Other initiatives give providers resources and materials, including health-related tools from organizations that support awareness of gaps in care and information on culturally competent care.

You may view a complete copy of Humana's Cultural Competency Plan on Humana's website at Language assistance and diversity~~Humana.com/provider/ news/language-assistance-program~~. To request a paper copy of Humana's Cultural Competency Plan, please call Humana Healthy Horizons ~~in Louisiana~~ Customer Care~~Service~~ at **1-800-4HUMANA (~~800-~~448-6262)** or call your provider contracting representative. ~~The~~ A copy of Humana's Cultural Competency Plan will be provided at no charge.

Advance directives

PCPs are responsible for discussing advance medical directives at the first medical appointment with adult members who are 18 or older and of sound mind ~~at the first medical appointment~~. The discussion should subsequently be charted in the member's permanent medical record. A copy of the advance directive should be included in the member's medical record along with other mental health directives.

The PCP should discuss potential medical emergencies with the member and document that discussion in the member's medical record.

Mental health advance directive

Mental health advance directives allow~~s a~~ member~~s~~ to make decisions related to their mental health treatment in advance. This includes but is not limited to psychoactive medication, short-term (not to exceed 15 days) admission to a treatment facility, electroshock therapy and outpatient services.

- The mental health advance directives will only be considered valid if ~~two~~ 2 ~~physicians~~ providers believe the member ~~are~~ is incapacitated and unable to make an informed decision. The document also allows the member to appoint ~~a person~~someone as a representative to make treatment decisions.

A copy of the mental health advance directive should also be included in the member's permanent medical record and

shared with all providers involved in the member's treatment plan.

Chapter 12~~HAPTER XII~~: Care management programs~~ARE MANAGEMENT PROGRAMS~~

Care management

Humana Healthy Horizons~~ in Louisiana's~~ c~~C~~are m~~M~~anagement p~~P~~rogram is a holistic and fully integrated health management program. We provide comprehensive and integrated services starting with the initial member assessment across the continuum of care focused on both acute and chronic condition management within behavioral health and physical

health.

Our personalized approach includes an MDT that includes:
- Medical and behavioral health nurses
- Social workers and other licensed behavioral health professionals
- Outreach specialists: ~~community health workers~~CHWs, housing specialists, ~~Social Determinants of Health (~~SDOH~~)~~ coordinators, peer support specialists
- Pharmacists

We place the member at the center of the care management process by:
- Helping the member identify personal health goals and priorities
- Supporting the member in reaching those goals
- Educating the member in how to self-manage chronic and infectious diseases
- Establishing interventions to manage chronic disease and reduce associated risks
- Providing guidance to support healthy living and compliance with plans of care
- Stressing the importance of identifying early and ongoing barriers to care
- Partnering with the member to enhance medical appointment compliance

Our care management approach supports and enhances the care and treatment you provide.

Our MDT collaborates with ~~you~~ the p~~P~~rovider to ensure the best and most comprehensive care for our members. This collaborative approach can support ~~your~~ patient's health and well-being by:
- Reducing admission and re~~-~~admission risks
- Managing anticipatory transitions
- Engaging non~~-~~compliant members
- Reinforcing medical instructions
- Assessing SDOH

We encourage and invite ~~you~~ providers to take an active role in the ~~your~~ patient~~'s~~ care management program, participate in the development of a comprehensive care plan~~,~~ and become part of an MDT by reaching out to our care management team at 1-**800-448-3810 (TTY: 711)**.

Member plans of care and health needs assessments are viewable on Humana Healthy Horizons' ~~in Louisiana's~~ provider portal and are available upon request by calling our care management team at **1-800-448-3810 (TTY: 711)**.

Referrals

We offer individualized member education and support for many conditions and needs, including assistance with housing and accessing community support.

Direct access for member care management referrals and needs assistance is available by calling **1-800-448-3810 (TTY: 711)**,
~~from 8 a.m. to 5 p.m.,~~ Monday through Friday, 8 a.m. to 5 p.m.~~,;,~~ ~~Central time by calling~~

~~**800-448-3810,**~~ by faxing ~~to~~ 1-**833-981-0204**; or emailing us at LAMCDCaseManagement@humana.com.

A r~~R~~eferral form is available at Provider d~~D~~ocuments and f~~F~~orms ~~–~~ — Louisiana Medicaid for p~~P~~roviders | Humana to make referring easier via email. We encourage you to refer members who might need individual attention to help them manage special healthcare challenges.

Intensive complex care management for high-risk members

High-risk members require the most focused attention to support their clinical care needs and address SDOH. Members involved in this level of care management receive monthly contacts to review plans of care and quarterly re~~-~~assessment for changing needs. This includes in-person and telephonic interventions.

Care management activities may integrate ~~community health worker~~CHWs and~~,~~ peer or specialist support. Case managers focus on implementing the member's plan of care, preventing institutionalization and other adverse outcomes, and supporting the member in self~~-~~managing ~~his or her~~the member's ~~ir~~ care goals.

Direct access for member care management referrals and needs assistance is available from 8 a.m. to 5 p.m., Monday through Friday, ~~Central time,~~ by calling

1-800-448-3810 (TTY: 711), faxing to **1-833-981-0204** or emailing us at LAMCDCaseManagement@humana.com.

Care management for medium-risk members

Medium-risk~~These~~ members may demonstrate rising risk and need focused attention to support their clinical care needs and to address SDOH. Members in this level of care have monthly care management follow-up and annual re-assessment.

Care management for low-risk members

Low-risk members may require support with care coordination and in addressing SDOH. These members have quarterly care management follow-up and annual re-assessment, along with ~~and~~ plan of care updates through in-person or telephonic outreach.

Transitional care management

Care management activities may integrate ~~community health worker~~CHWs and~~,~~ peer or specialist support as members transition from one care setting to another or back into their community. Case managers focus on implementing~~ation of~~ the member's plan of care, preventi~~o~~ng ~~of~~ institutionalization and other adverse outcomes, and supporting the member in self-managing the member's~~ir~~ care goals. Specifically, transitional care management also includes:

- Support for members as they transition from inpatient care to the community~~.~~
- Follow-up appointment support~~.~~
- Reliable delivery of at-home and/or post-discharge items~~.~~
- A r~~R~~eview of discharge instructions and medication changes

HumanaBeginnings ~~®~~prenatal program

Humana's HumanaBeginnings® p~~P~~rogram provides perinatal and neonatal care management utilizing a specialized staff. ~~Nurses~~ Experienced maternity care nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members.

The expertise offered by the staff includes a focus on patient education and support and involves in~~-~~-person and ~~direct telephone~~telephonic contact with members and providers. We encourage our prenatal care providers to notify the c~~C~~are m~~M~~anagement team at 1~~-~~**800-448-3810 (TTY: 711)** when a member with a high-risk pregnancy is identified or when they would like to refer a patient to the program.

We encourage providers to fax ~~us~~ the state ~~Notice of Pregnancy form, available at~~ Medicaid Notification of Pregnancy Form~~https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=5117762,~~ to 1~~-~~**833-982-0053**.

Chapter~~HAPTER~~ 13~~XIII~~: Population health programs and incentives ~~OPULATION HEALTH PROGRAMS AND INCENTIVES~~

Population h~~H~~ealth programs are offered to encourage and reward behaviors designed to improve a member's overall health. Programs administered by Humana Healthy Horizons ~~in Louisiana~~ must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the ~~U.S. Department of Health and Human Services, Office of Inspector~~HHS~~ General (~~OIG~~)~~. The following population health programs are offered to Humana Healthy Horizons ~~in Louisiana's~~ members:

Go365 for Humana Healthy Horizons

Go365 for Humana Healthy Horizons® is a wellness program that offers members the opportunity to earn rewards for taking healthy actions. Most of the rewards are dependent ~~up~~on Humana Healthy Horizons ~~in Louisiana~~ receiving the provider's claim for services rendered.

Humana Healthy Horizons ~~in Louisiana~~ recommends that all providers submit their claims on behalf of a member by end of December 202~~3~~4. This allows ~~the~~ member~~s~~ time to redeem their reward~~s~~.

The Go365 for Humana Healthy Horizons mobile app~~lication~~ is available for members to download from Android and iPhone app stores. After members register their account, they can access the app's features and begin earning and redeeming rewards with points accumulated after completing key activities.

Activity	Reward details
Annual wellness visits (age 3 to 20)	$25 in rewards for members who complete 1 annual wellness visit
Behavioral health follow-up visit	$25 in rewards when a follow-up visit occurs within 30 days after discharge for hospitalization for behavioral health diagnosis
Breast cancer screening (age 40 and older)	$25 in rewards for female members who obtain a mammogram once per year~~.~~

Cervical cancer screening (age 2121 and older)	$25 in rewards for female members who obtain a Ppap testsmear once per year.
Chlamydia screening	$25 in rewards for female members who obtain a chlamydia screening when sexually active or as recommended by their healthcare provider
Colorectal cancer screening (age 45 and older)	$25 in rewards for members who obtain a colorectal cancer screening as recommended by their PCP once per year.
COVID-19 vaccine	$20 in rewards for members who upload a picture/file of their completed COVID-19 vaccine card, 1 per year. Members who were vaccinated prior to enrollment in the Humana Healthy Horizons plan may upload vaccination card within 90 days of enrollment to receive the rewards. New members who were not vaccinated prior to enrollment in Humana Healthy Horizons, have 90 days from completion of vaccination and to upload the vaccination card to receive the rewards.
Diabetic retinal eye exam (age 18 and older)	$25 in rewards for diabetic members who complete a retinal eye exam once per year.

Activity	Reward details
Diabetic screening (age 18 and older)	$50 in rewards for diabetic members who complete an annual screening with their PCP for HbA1c and blood pressure once per year.
Digital onboarding	$25 in rewards for downloading and registering on the Go365 for Humana Healthy Horizons mobile app
Flu vaccine	$20 in rewards for members who receive an annual flu vaccine from their provider or, pharmacy or from a self-reporting if they received thea vaccine from another source.
Health needs assessment (HNA)	$30 in rewards for members who complete their hHealth nNeeds aAssessment (HNA) within 90 days of enrollment with Humana Healthy Horizons, one reward per lifetime.
High-intensity care of SUD	$25 in rewards when a follow-up visit occurs within 30 days after discharge for hospitalization for members who have inpatient care, residential treatment or detoxification visits
Human papillomavirus vaccine (HPV)	$50 in rewards for members age 9–13 upon completion of both doses
Level of care video	$10 in rewards for members age 19 and older who complete education for when to access the emergency room (ER)
Notification of pregnancy form	$25 in rewards when pregnant members complete the notification of pregnancy form prior to delivery
Postpartum visit	$25 in rewards for all postpartum females who complete 1 postpartum visit within 7––84 days after delivery, once per pregnancy.
Prenatal visit	~~$25 in rewards for all pregnant females who complete 1 prenatal visit within the first trimester or 1 prenatal visit within 42 days of enrollment with Humana, one reward per pregnancy.~~ $10 in rewards per visit, up to $100 for 10 prenatal visits, f. For all pregnant females.

Tobacco cessation coaching (12 and older)	For all members 12 and older, up to 8 health coaching/cessation support calls within 12 months from enrollment date. For members 18 and older, nicotine replacement therapy upon request. This program will have two2 opportunities where members can earn rewardsfor members to earn rewards. • $25 in rewards for members who complete 2 calls within the first 45 days of enrollment in the coaching program. • $25 in rewards for members who complete 6 additional wWellness cCoaching calls (total of 8) within 12 months of the first coaching session, one per year.
Weight management program (age 12 and older)	Enrollment in wWeight mManagement pProgram, completion of a well-being check-up and form with their primary care provider (PCP), completion of 6 total wellness coaching calls within 12 months of enrollment date or return of the PCP form. This program will have two2 opportunities for members to earn rewardswhere members can earn rewards. $30 in rewards: Enrollment in the wWeight mManagement pProgram • Completion of well-being check-up with PCP • Submission of PCP form $20 in rewards: Completion of the program • 6 wellness coaching calls within 12 months of the first coaching session
Well-child visits (age 0–15 months)	Up to $120 in rewards;, members who complete a well-child visit are eligible for $20 in rewards per visit, with a 6-visit limit.
Well-child visits (16–30 months)	Up to $30 in rewards;, members who complete a well-child visit are eligible for $15 in rewards per visit, with a 2-visit limit.
Annual wellness visits (age 3 to 20)	$25 in rewards for members who complete 1 annual wellness visit.
Human pPapillomavirus vVaccine (HPV)	$50 in rewards for members ages 9 – 13 upon completion of both doses
Level of cCare vVideo	$10 in rewards for members ages 19 and older+ who complete education for when to access the emergency room (ER)
Notification of pPregnancy form	$25 in rewards when pregnant enrollees complete the notification of pregnancy form prior to delivery
Chlamydia sScreening	$25 in rewards for female enrollees who obtain a chlamydia screening when sexually active or as recommended by their healthcare provider
Behavioral hHealth fFollow-up vVisit	$25 in rewards when a follow-up visit occurs within 30 days after discharge for hospitalization for behavioral health diagnosis
High iIntensity cCare of Substance Use DisorderSUD	$25 in rewards when a follow-up visit occurs within 30 days after discharge for hospitalization for enrolleesmembers who have inpatient care, residential treatment or detoxification visits.
Digital oOnboarding	$25 in rewards for downloading and registering on the Go365 for Humana HelathyHealthy Horizons mobile application

Once members are enrolled, Humana Healthy Horizons in Louisiana will inform them about the population health programs, including incentives and rewards. Incentives and rewards cannot be used for gambling, alcohol, tobacco or drugs (except for over-the-counter OTC drugs). All programs, including incentives and rewards, are made available to all members who meet program requirements. Members younger than 13 must have a parent or guardian download the app, sign in and log healthy behaviors on the child's behalf. Members younger than 13 and in state care are ineligible for the Go365 program.

The maximum-reward -dollar amount for incentives and rewards does not include money spent on transportation, child

care provided during delivery of services or healthy behavior program services.

Incentives and rewards may take more than 180 days to be delivered and are non-transferable to other MCOs. Members lose access to earned incentives and rewards upon voluntary disenrollment from Humana Healthy Horizons ~~in Louisiana Medicaid~~ or if Medicaid eligibility is lost for more than 180 days.

If you would like to refer a member for any of the above programs, please call our care management department at 1-**800-448-3810** (TTY: 711) or email a referral to LAMCDCaseManagement@humana.com.

Interpreter services

Hospital and non-hospital providers are required to abide by federal and state regulations regarding sections 504 and 508 of the Rehabilitation Act of 1973, and Executive Order 13166 and Section 1557 of the Americans with Disabilities Act (ADA). For deaf members, the Affordable Care Act (ACA) includes providing in-person, phone or video remote interpretation services in at least 150 non-English languages.

These services are available at no cost to the patient or member per federal law. If you need assistance in fulfilling this obligation, please call 1-**877-320-1235**.

Health education

Humana Healthy Horizons in Louisiana members receive health information in various ways, including easy-to-read newsletters, brochures, phone calls and personal interactions. Humana Healthy Horizons also sends preventive care reminder messages via mail and automated outreach messaging.

ChapterHAPTER 14XIV: Value-added benefits ALUE-ADDED BENEFITS

Value added benefits are those services offered by Humana Healthy Horizons in Louisiana and approved in writing by LDH. Such benefits are not otherwise covered or exceed limits outlined in the Louisiana Medicaid sState pPlan and Medicaid fee schedules. These services are in excess of the amount, duration and scope of the services listed above.

In instances where a value-added benefit also is a Medicaid covered service, Humana Healthy Horizons in Louisiana will administer the benefit in accordance with any applicable service standards pursuant to our contract, the Louisiana Medicaid sState Pplan and any Medicaid coverage and limitations handbooks.

Humana Healthy Horizons in Louisiana has committed to offeringoffers the following value-added benefits:

Value-added benefits	Description
Cell phone services	Free cell phone through the Federal Lifeline Program, per household. Members who are under 18 will need a parent or guardian to sign up This benefit covers per lifetime: 1 phone, 1 charger, 1 set of instructions, 350 minutes per month, 4.5 GB of data per month, unlimited text messages per month, training for you and your caregiver at the first case manager orientation visit. This benefit also includes unlimited calls to Humana Member Services for health plan assistance and 911 for emergencies even if you run out of minutes. You must make at least 1 phone call or send 1 text message every month to keep your benefit. You may also qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, 5 GB hotspot and 25 GB of data. You can opt into this benefit by calling SafeLink at **877-631-2550** or online at safelink.com Benefits are subject to change by the FCC under the Lifeline program
Convertible cCar sSeat or pPortable cCrib	Pregnant members who enroll and actively participate in our HumanaBeginnings cCare mManagement program and complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings cCare mManager can select 1 convertible car seat or portable crib per infant, per pregnancy.

Dental ~~services~~ (age 21 and older)	Up to a $500 allowance is allowed toward services with in-network providers, such as routine dental exams, X-rays, cleanings, filings~~,~~ and extractions ~~with in-network providers~~. ~~$500 annual allowance toward preventive services, exams, extraction and restorative services with in-network providers~~
Disaster p~~P~~reparedness m~~M~~eals	One box of 14 shelf-stable meals is provided after a hurricane or tornado, twice per year. The g~~G~~overnor must declare the tornado or hurricane a disaster for the ~~M~~member to be eligible for the meals.
Drowning prevention classes (age 0~~-~~–21 years)	Drowning prevention classes are offered with ~~the~~ a free Y~~MCA~~ membership. If the member does not reside within 20 miles of a partnering Y~~MCA~~, or if a partnering Y~~MCA~~ within 20 miles does not offer swimming lessons, the member is eligible for reimbursement of up to $200 annually for swimming lessons for infants and children from a certified swim instructor.
GED testing ~~preparation~~ (age 16 and older)	GED test preparation assistance is offered, including access to a bilingual advisor~~, access to~~ and guidance and study materials, along with ~~and~~ unlimited use of practice tests. Test preparation assistance is provided virtually to allow maximum flexibility for members. It a~~A~~lso includes a test pass guarantee to provide members multiple with attempts at passing the test. This is for members age 16~~-~~–18 years~~; : must provide~~ additional documentation must be provided. Underage test-takers: Underage testers must enroll in the state's official a~~A~~dult e~~E~~ducation p~~P~~rogram and take free classes until they are ready to sit for the exam. They will need documentation from the school system that they have officially withdrawn.

Value~~-~~added benefits	Description
Home-based interventions for asthma	Interventions are offered u~~U~~p to $200, once per year. Members with asthma can utilize this allowance toward~~s~~ carpet clearing, allergen free bedding and/or an air purifier. The member m~~M~~ust have an asthma diagnosis. This m~~M~~ust be approved by a ~~C~~care m~~M~~anager~~-~~.
Housing assistance (age 21 and older)	Up to $500 per member, per lifetime, is offered to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water, gas or internet (late payment notice required) • Trailer p~~P~~ark and lot rent if ~~this is your~~ permanent residence (late payment notice required) • Moving expenses via a licensed moving company when transitioning from a public housing authority This m~~M~~ust be approved by a c~~C~~are m~~M~~anager. • The m~~M~~ember must not live in a residential ~~facility~~ or nursing facility. • Funds will not be paid directly to the member.

	• If the bill is in the spouse's name, a marriage certificate may be submitted as proof. ~~Note: Funds will not be paid directly to the member. If the bill is in the spouse's name, a marriage certificate may be submitted as proof.~~
Newborn circumcision (age 0 ~~to~~ 12 months)	This is offered u~~U~~p to 12 months of age or as medically necessary, ~~.~~ ~~O~~once per lifetime.
~~Nonm Medical t~~Transportation (NMT) ~~(age 18 and older)~~	~~Up to 15 round trips (or 30 one-way trips), up to 30 miles, are offered for non-medical transportation per year to locations such as social support groups;, wellness classes;, WIC and Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) appointments;, food banks;, and applicable value-added benefit services offered. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas, and churches.~~
None ~~E~~mergency m~~M~~edical t~~T~~ransportation (NEMT) (age 18 and older)	Rides are offered for up to 30 miles to medical appointments with a stop at a pharmacy for medications.
Nonmedical transportation (NMT) (age 18 and older) ~~Meals-disaster preparedness/relief~~	Up to 15 round trips (or 30 one-way trips), up to 30 miles, are offered for nonmedical transportation per year to locations such as social support groups; wellness classes; Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) appointments; food banks; and applicable value-added benefit services. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas and churches. ~~One box of 14 shelf-stable meals after a hurricane or tornado, twice per year (The Governor must declare the tornado or hurricane a disaster for the Member to be eligible for the meals.)~~
~~Meals-post discharge~~	~~Up to 14 home-delivered meals following discharge from an inpatient or residential facility, (up to 4 discharges).~~
~~Newborn circumcision (0 to 12 months)~~	~~Up to 12 months of age or as medically necessary. Once per lifetime.~~
~~Over-the-counter (~~OTC~~)~~ pharmacy allowance	An u~~U~~p to $25 per calendar month allowance enables members to purchase products that support common occurring conditions such as: • Pain relivers • Diaper rash cream • Cough and cold relief medicine • First aid equipment that does not require a prescription~~s.~~ Unused amounts do not roll over to the next month. ~~Up to $25 per calendar month for OTC (over-the-counter) medicines like pain relievers, diaper rash cream, cough and cold, and first aid. Prescription not necessary. Amounts not used will not roll over.~~

Pain management alternatives -— acupuncture services (age 21 and older)	Up to 24 annual acupuncture visits are offered to manage chronic pain. Members suffering from chronic pain and/or opioid use disorder can take advantage of 24 acupuncture visits per year.
Pain management - massage therapy (21 and older)	Members suffering from chronic pain and/or opioid use disorder can take advantage of 24 massage visits per year.
Portable cribs	One portable crib per infant per pregnancy. Member must consent to participate in the HumanaBeginnings® program, complete the comprehensive assessment, and complete 1 additional follow-up call within 56 days, or 8 weeks, of enrollment or identification of a pregnancy indicator.
Post-d Dischargе mMeal	14 refrigerated home-delivered meals are provided following discharge from an inpatient or residential facility. l. Limited to 4 discharges per year.
Respite care for homeless program (males age s 18 and older)	The Medical Respite pProgram ensures member recovery and stabilization and, successful member integration back into the community, and reducesing unnecessary emergency department visits and hospital admissions.
Smartphone sServices	1 fFree smartphone is offered through the fFederal Lifeline Program, per household. Members who are under 18 will need a parent or guardian to sign up. This benefit covers the following per lifetime: 1 phone;, 1 charger;, 1 set of instructions;, unlimited tTalk, text and high-speed data;, and training for you and your caregiver at the first case manager orientation visit if you are enrolled in care management. Members must make 1 phone call or send 1 text message every month to keep the benefit. Members may qualify for enhanced benefits through the Affordable Connectivity Program (ACP), which that provides unlimited minutes, a 10 GB hotspot and unlimited data. You can opt into this benefit by contactingcalling SafeLink at **1-800-SAFELINK (723-3546)** or online at SafeLink Wireless www.safelink.com/en/ACP11. Benefits are subject to change by the Federal Communications Commission F13 under the Lifeline Pprogram.
Sports physical (age 6 — 18 years)	1 sports physical is provided per year.
Tobacco and v& Vaping cCessation cCoaching (age 12 and older)	The tTobacco cCessation pProgram is focused on tobacco and vaping cessation coaching for members aged 12 and older. — The program is designed as a 6-month engagement for a total of 8 coaching calls, but members have 12 months to complete the program if needed. Humana Healthy Horizons's tobacco and vaping cessation health coaching program offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT).
Vision services (age 21 and older)	1 eye exam is offered per year. Up to a $100 allowance is offered for 1 set of glasses (frames and lenses) or contacts, but not both, during the plan year. Member pays any cost over $100.
Weight mManagement cCoaching (age 12 and older)	The wWeight mManagement cCoaching pProgram delivers weight management intervention for members who are 12 and older. Upon receiving physicianprovider clearance, members can complete six (6) weight management coaching sessions with a hHealth cCoach and ; approximately one1 call per month, for a period of six (6) months.

Y~~MCA Gym~~ membership	Free one-year membership at any participating Y~~MCA~~.

ChapterHAPTER 15: PXV: PHarmacy

Humana Healthy Horizons provides coverage of medically necessary medications prescribed by Louisiana Medicaid licensed prescribers. Humana Healthy Horizons in Louisiana provides coverage of medically necessary medications, prescribed by Medicaid certified licensed prescribers in the state. Humana Healthy Horizons in Louisiana adheres to state and federal regulations on medication coverage for our members. The member's prescription drug benefit is provided by Prime Therapeutics.by Magellan Medicaid Administration.[DB158]

Utilization Management (UM)

The Humana Healthy Horizons Preferred Drug List identifies covered drugs and associated drug Utilization Management UM requirements, such as prior authorization, quantity limits, etc.

- Prior authorization: Tthe medication must be reviewed using a criteria-based approval process prior to coverage decision.
- Age/qQuantity limits: The prescriber must facilitate the appropriate, approved label use of various classes of medications. -
- Prior aAuthorizations for the pharmacy benefit are completed by Prime Therapeutics.Magellan Medicaid Administration[DB159] and can be requested by:
  - –Phone Request: 1-**800-424-1664**
  - –Fax Request: 1-**800-424-7402**
  - – Electronic RequestOnline: CoverMyMedsCoverMyMeds

Coverage limitations

The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories or drugs covered with restrictions:

- Agents used for anorexia, weight gain or weight loss (oOrlistat covered only)
- Agents used to promote fertility
- Agents used for symptomatic relief of for cough and colds, except for antihistamine and antihistamine/decongestant combination products
- Agents used for cosmetic purposes or hair growth
- Agents used for erectile dysfunction
- Compounded prescriptions (mixtures of two 2 or more ingredients; the individual drugs will continue to be reimbursed)
- Drug Efficacy Study Implementation (DESI) d-Drugs (refer to those drugs that the FDA has proposed to withdraw from the market because they lack substantial evidence of effectiveness)
- Narcotics prescribed only for narcotic addiction[MMB160][DB161][DB162]opioid use disorder
-

Non-legend or OTC drugs or items with some exceptions when accompanied by a prescription and on the Louisiana Department of Health PDL: PDL.pdf (la.gov)Non-legend or OTC drugs or items with some exceptions

-

Immunizations

Humana Healthy Horizons in Louisiana covers Advisory Committee on Immunization Practices (ACIP) vaccines.

- For members age 18 and younger, vaccinations are provided free of charge through the Louisiana Immunization Program/Vaccines for Children (VFC) Pprogram.
- For members age 19 and older, vaccines and vaccine administration are covered without restriction or prior authorization.

Copay

Medications may have a small copay for members 21 and older based on calculated state payment. The following table shows the copay amounts:

Monthly iIncome	Copay
When 5% of family's monthly income is spent on copays	$0
Medication cCost	**Copay**
$5.00 or less	$0
$5.01–$10.00	$0.50

~~$10.00 or less~~	~~$0.50~~
$10.01 – $25.00	$1.00
$25.01 – $50.00	$2.00
$50.01 or more	$3.00

However, there are no co-pays for the following members:

- Individuals 21 and younger
- Pregnant women
- Individuals who are inpatients in long-term care facilities or other institutions
- Family planning services and supplies
- Emergency services
- Native Americans
- Alaskan Eskimos
- Women who are receiving services ~~on the basis of~~due to breast ~~and~~ or cervical cancer
- Beneficiaries receiving hospice services

Pharmacy lock-in program

The l~~L~~ock-in p~~P~~rogram is designed for individuals enrolled in Louisiana Medicaid ~~in Louisiana~~ who need help managing their use of prescription medications. It is intended to limit overuse of benefits while providing an appropriate level of care for the member.

Humana Healthy Horizons ~~in Louisiana~~ members who meet the program criteria will be locked in to ~~one~~ 1 pharmacy and/or ~~one~~ 1 prescriber (group). A specialty pharmacy will be added on an as-needed basis. The l~~L~~ock-in p~~P~~rogram is required by ~~the Louisiana Department of Health~~LDH.

Humana Healthy Horizons ~~in Louisiana~~ monitors claim activity for signs of misuse or abuse in accordance with state and federal laws. If ~~a~~ review of a member's claim activity reveals an unusually large number of controlled substance prescriptions or misuse of prescriptions, the member is considered a candidate for the l~~L~~ock-in p~~P~~rogram.

Members identified to be enrolled in the lock-in program receive written notification from Humana Healthy Horizons ~~in Louisiana~~, along with the designated lock-in pharmacy and/or prescriber's (group) information.

~~Over-the-counter (~~Over-the-counter ~~TC)~~ h~~H~~ealth and w~~W~~ellness

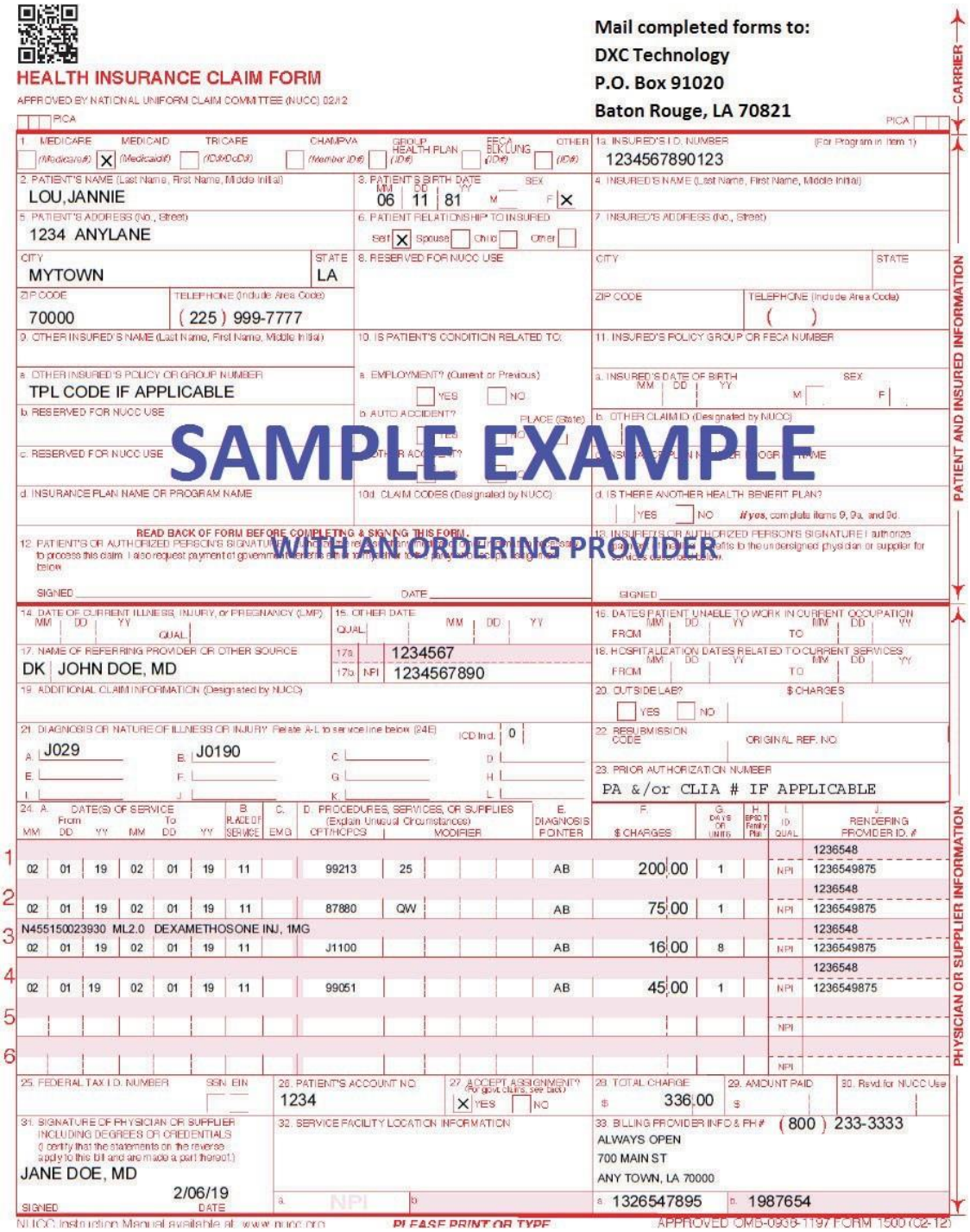
Humana Healthy Horizon ~~in Louisiana~~ members have an expanded pharmacy benefit, which provides a $25 per~~/~~ month allowance to spend on OTC health and wellness items. These OTC~~s and~~ products will be sent by mail within 10-14 working days after the order is made. There is no charge to the member for shipping.

References

1. "Public Policy Statement: Definition of Addiction," American Society of Addition Medicine, last accessed April 9, 2024, 1definition_of_addiction_long_4-11.pdf.
2. "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, last accessed April 9, 2024, https://www.samhsa.gov/find-help/recovery.
3. Francis K. Amankwah, Joe Alper, and Sharyl J. Nass. 2024. "Unequal Treatment Revisited: The Current State of Racial and Ethnic Disparities in Health Care." Washington, DC: National Academies Press.

Appendix
LDH clean claim samples

Sample of professional claim form — ~~AMPLE OF PROFESSIONAL CLAIM FORM —~~ revised ~~REVISED~~ Aug. 15, 2019~~8/15/2019~~



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Mail completed forms to:
DXC Technology
P.O. Box 91020
Baton Rouge, LA 70821

CARRIER

1. MEDICARE [X] (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOU,JANNIE
3. PATIENT'S BIRTH DATE: 06 11 81 SEX: M F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 ANYLANE
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other
7. INSURED'S ADDRESS (No., Street):

CITY: MYTOWN STATE: LA
8. RESERVED FOR NUCC USE
CITY STATE

ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 999-7777
ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State) YES NO
b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

SAMPLE EXAMPLE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

WITH AN ORDERING PROVIDER

SIGNED DATE
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JOHN DOE, MD
17a. 1234567
17b. NPI 1234567890
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. J029 B. J0190 C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: PA &/or CLIA # IF APPLICABLE

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 02 01 19	02 01 19	11		99213	25	AB	200 00	1		NPI	1236548 / 1236549875
2 02 01 19	02 01 19	11		87880	QW	AB	75 00	1		NPI	1236548 / 1236549875
3 N455150023930 ML2.0 DEXAMETHOSONE INJ, 1MG 02 01 19	02 01 19	11		J1100		AB	16 00	8		NPI	1236548 / 1236549875
4 02 01 19	02 01 19	11		99051		AB	45 00	1		NPI	1236548 / 1236549875
5										NPI	
6										NPI	

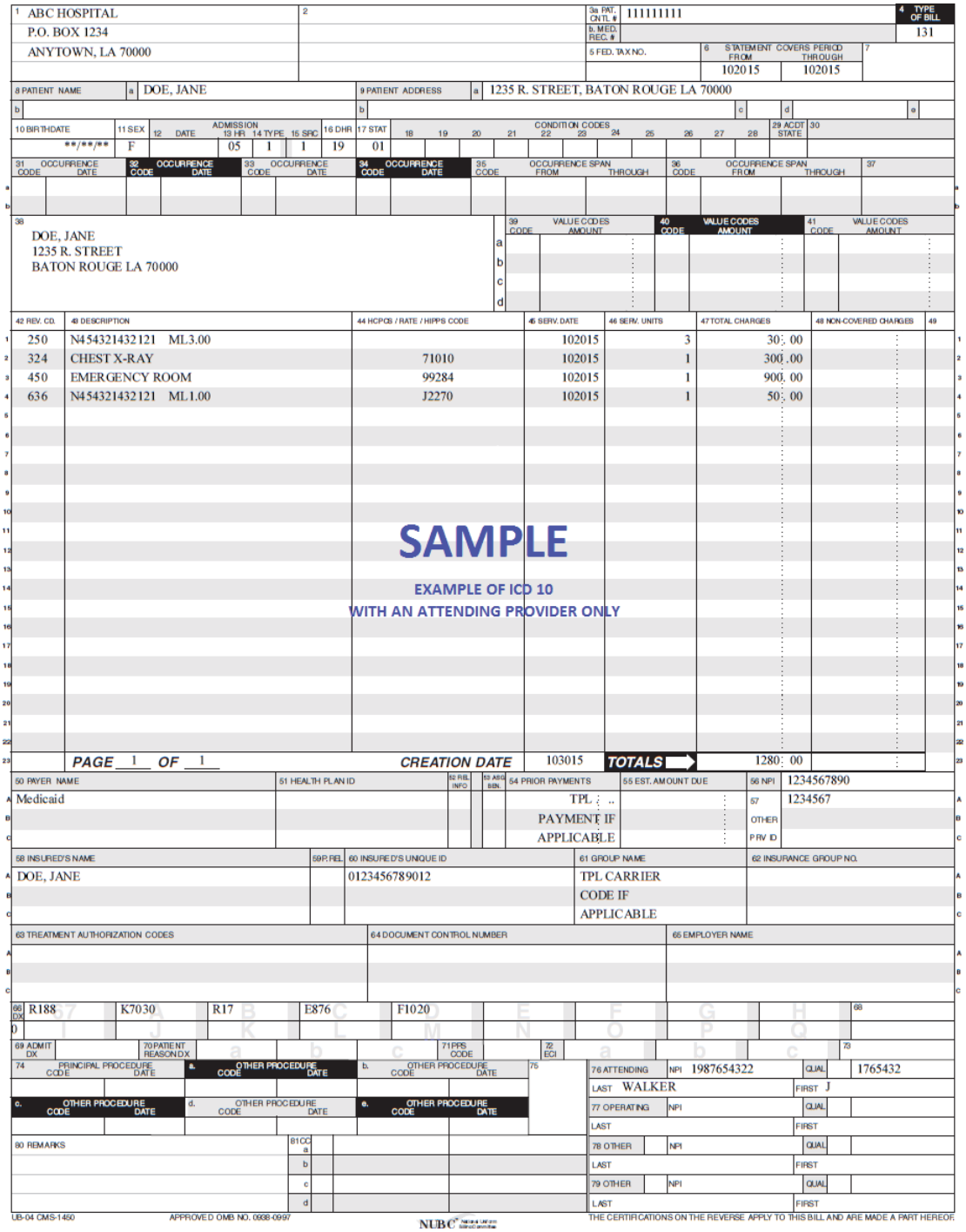
PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 1234
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO
28. TOTAL CHARGE $ 336 00
29. AMOUNT PAID $
30. Rsvd for NUCC Use

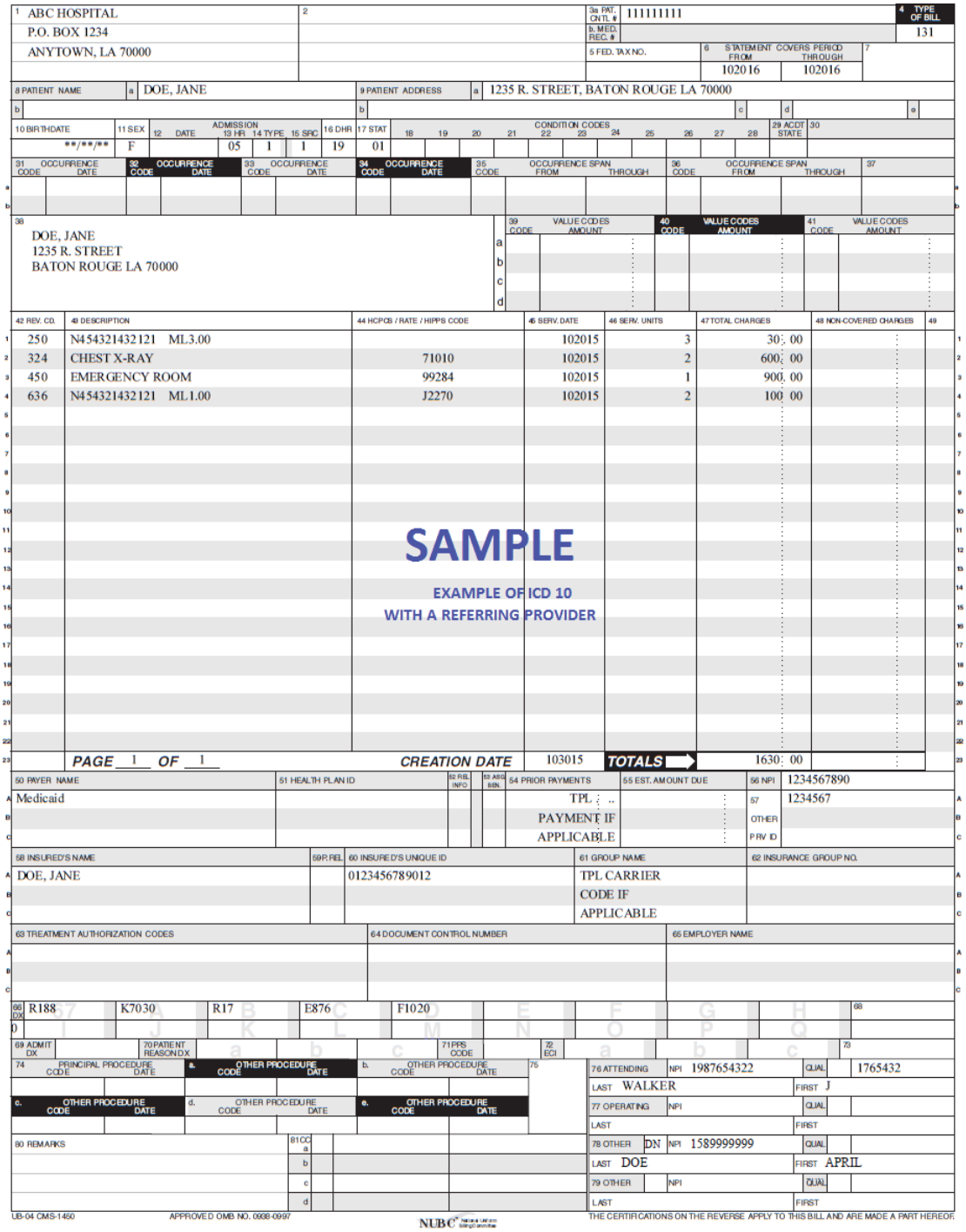
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JANE DOE, MD
SIGNED 2/06/19 DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # (800) 233-3333
ALWAYS OPEN
700 MAIN ST
ANY TOWN, LA 70000
a. 1326547895 b. 1987654

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample outpatient hospital claim form with an attending provider only (with ICD-10 diagnosis code dates on or after Oct. 1, 2015) ~~SAMPLE OUTPATIENT HOSPITAL CLAIM FORM WITH AN ATTENDING PROVIDER ONLY (WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)~~

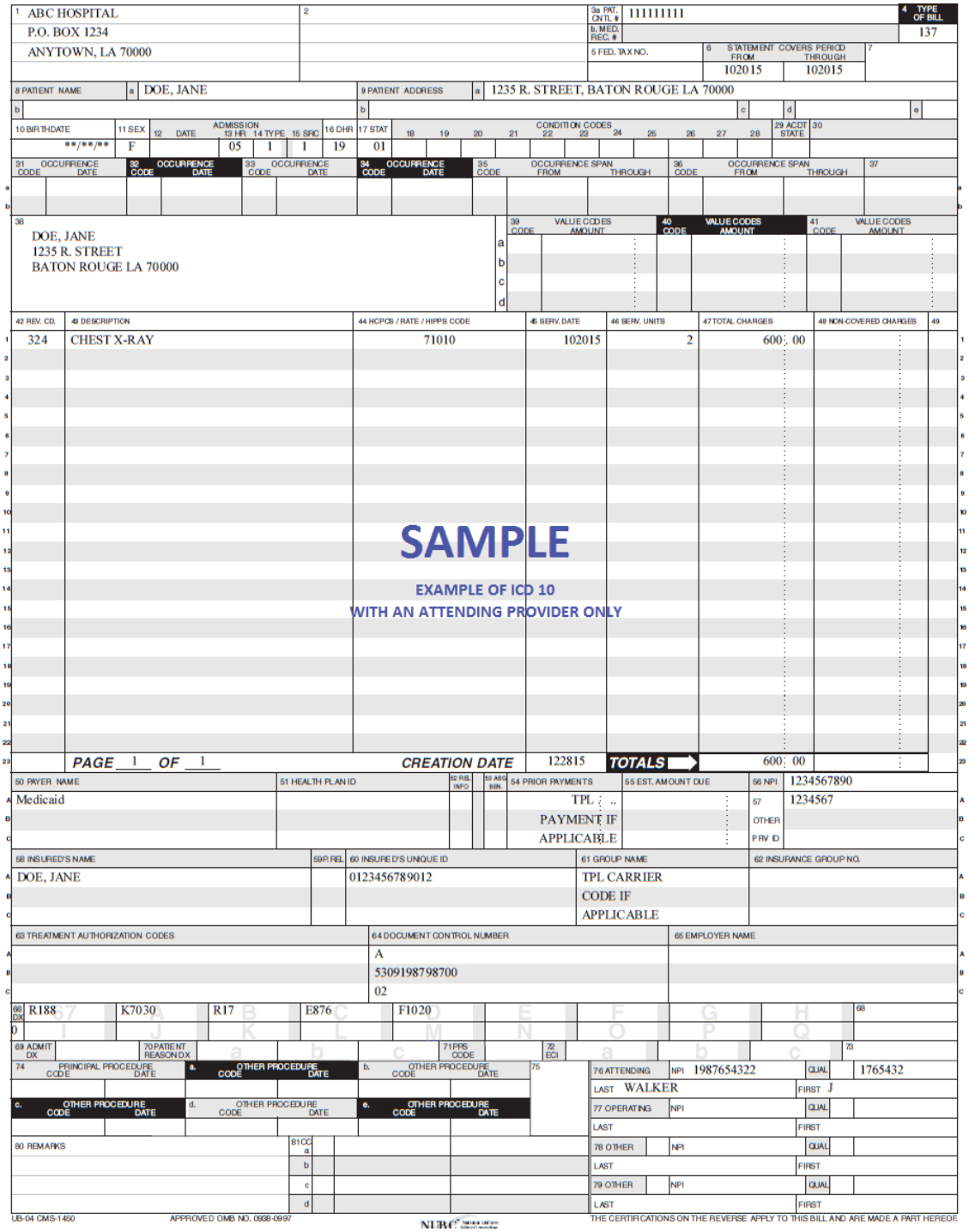


Sample outpatient hospital claim form with a referring provider (with ICD-10 diagnosis code dates on or after Oct. 1, 2015) ~~SAMPLE OUTPATIENT HOSPITAL CLAIM FORM WITH A REFERRING PROVIDER (WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)~~



Sample outpatient hospital claim form adjustment with an attending provider only (with ICD-10 diagnosis code dates on or after Oct. 1, 2015)

~~SAMPLE OUTPATIENT HOSPITAL CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY~~
~~(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)~~



Sample inpatient hospital claim form split billed with an attending provider only (with ICD-10 diagnosis code dates on or after Oct. 1, 2015) ~~SAMPLE INPATIENT HOSPITAL CLAIM FORM SPLIT BILLED WITH AN ATTENDING PROVIDER ONLY~~

~~(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)~~

1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111
b. MED. REC. #
4 TYPE OF BILL 114
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 100315

8 PATIENT NAME a DOE, JANE
9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE **/**/**
11 SEX F
ADMISSION 12 DATE 093015 13 HR 23 14 TYPE 1 15 SRC 2
16 DHR 15
17 STAT 01
CONDITION CODES 18 C1

31–37 OCCURRENCE CODE / DATE, OCCURRENCE SPAN CODE / FROM / THROUGH

38
DOE, JOHN
1235 R. STREET
BATON ROUGE LA 70000

39 VALUE CODES CODE a 80 AMOUNT 2 00
40 VALUE CODES CODE / AMOUNT
41 VALUE CODES CODE / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
112	Room and Board	1000.00		2	2000 00		
250	Pharmacy			22	570 89		
270	Medical/Surgical Supply			14	618 00		
272	Sterile Supply			2	142 57		
300	Laboratory- Gen Classific			3	270 00		
302	Lab/ Immunology			1	50 00		
305	Lab Hematology			5	80 86		
370	Anesthesia			1	759 00		
636	Drugs			8	619 85		
710	Recovery Room			116	2589 00		
720	Labor/Delivery			11	4563 00		
	PAGE 1 OF 1	CREATION DATE	100715	TOTALS	12263 17		

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

50 PAYER NAME A Medicaid
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS TPL PAYMENT IF APPLICABLE
55 EST. AMOUNT DUE
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME A DOE, JANE
59 P. REL
60 INSURED'S UNIQUE ID 0123456789012
61 GROUP NAME TPL CARRIER CODE IF APPLICABLE
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX O10013 Y Z370 N O714 N O701 N Z23 N
67 / 68

69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

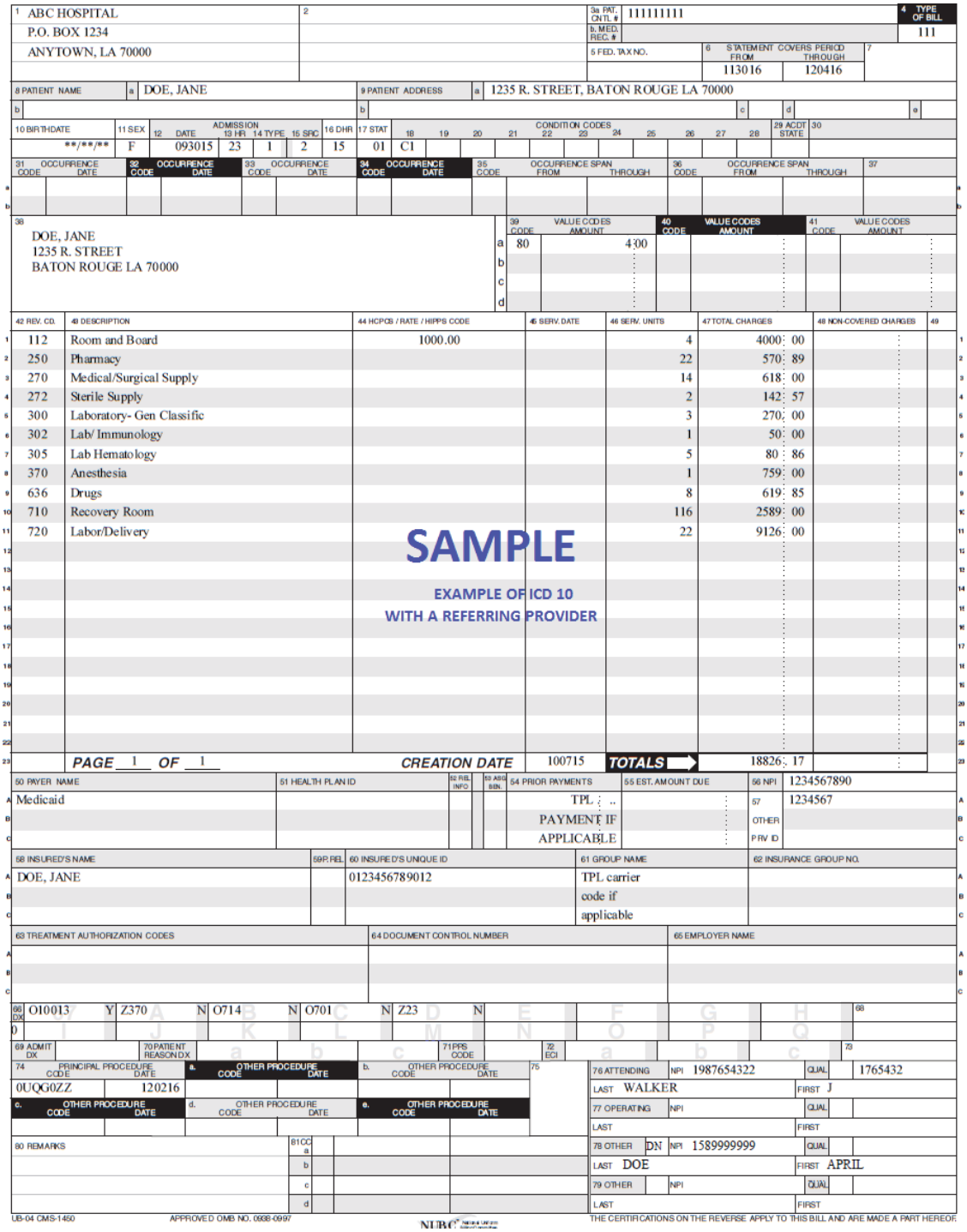
74 PRINCIPAL PROCEDURE CODE 0UQG0ZZ DATE 100114
a. OTHER PROCEDURE CODE / DATE
b. OTHER PROCEDURE CODE / DATE
c. OTHER PROCEDURE CODE / DATE
d. OTHER PROCEDURE CODE / DATE
e. OTHER PROCEDURE CODE / DATE
75

76 ATTENDING NPI 1987654322 QUAL 1765432
LAST WALKER FIRST J
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample inpatient hospital claim form not split billed with a referring provider (with ICD-10 diagnosis code dates on or after Oct. 1, 2015) ~~SAMPLE INPATIENT HOSPITAL CLAIM FORM NOT SPLIT BILLED WITH A REFERRING PROVIDER (WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)~~



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111
b. MED. REC. #
4 TYPE OF BILL 111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 113016 THROUGH 120416

8 PATIENT NAME a DOE, JANE
9 PATIENT ADDRESS a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE **/**/** | 11 SEX F | 12 ADMISSION DATE 093015 | 13 HR 23 | 14 TYPE 1 | 15 SRC 2 | 16 DHR 15 | 17 STAT 01 | CONDITION CODES 18 C1 | 29 ACDT STATE

38
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

39 VALUE CODES AMOUNT a 80 4:00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
112	Room and Board	1000.00		4	4000: 00	
250	Pharmacy			22	570: 89	
270	Medical/Surgical Supply			14	618: 00	
272	Sterile Supply			2	142: 57	
300	Laboratory- Gen Classific			3	270: 00	
302	Lab/ Immunology			1	50: 00	
305	Lab Hematology			5	80: 86	
370	Anesthesia			1	759: 00	
636	Drugs			8	619: 85	
710	Recovery Room			116	2589: 00	
720	Labor/Delivery			22	9126: 00	
	PAGE 1 OF 1	CREATION DATE	100715	TOTALS	18826: 17	

SAMPLE
EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

50 PAYER NAME A Medicaid
51 HEALTH PLAN ID
54 PRIOR PAYMENTS TPL .. PAYMENT IF APPLICABLE
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME A DOE, JANE
60 INSURED'S UNIQUE ID 0123456789012
61 GROUP NAME TPL carrier code if applicable
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 0 | O10013 Y | Z370 N | O714 N | O701 N | Z23 N

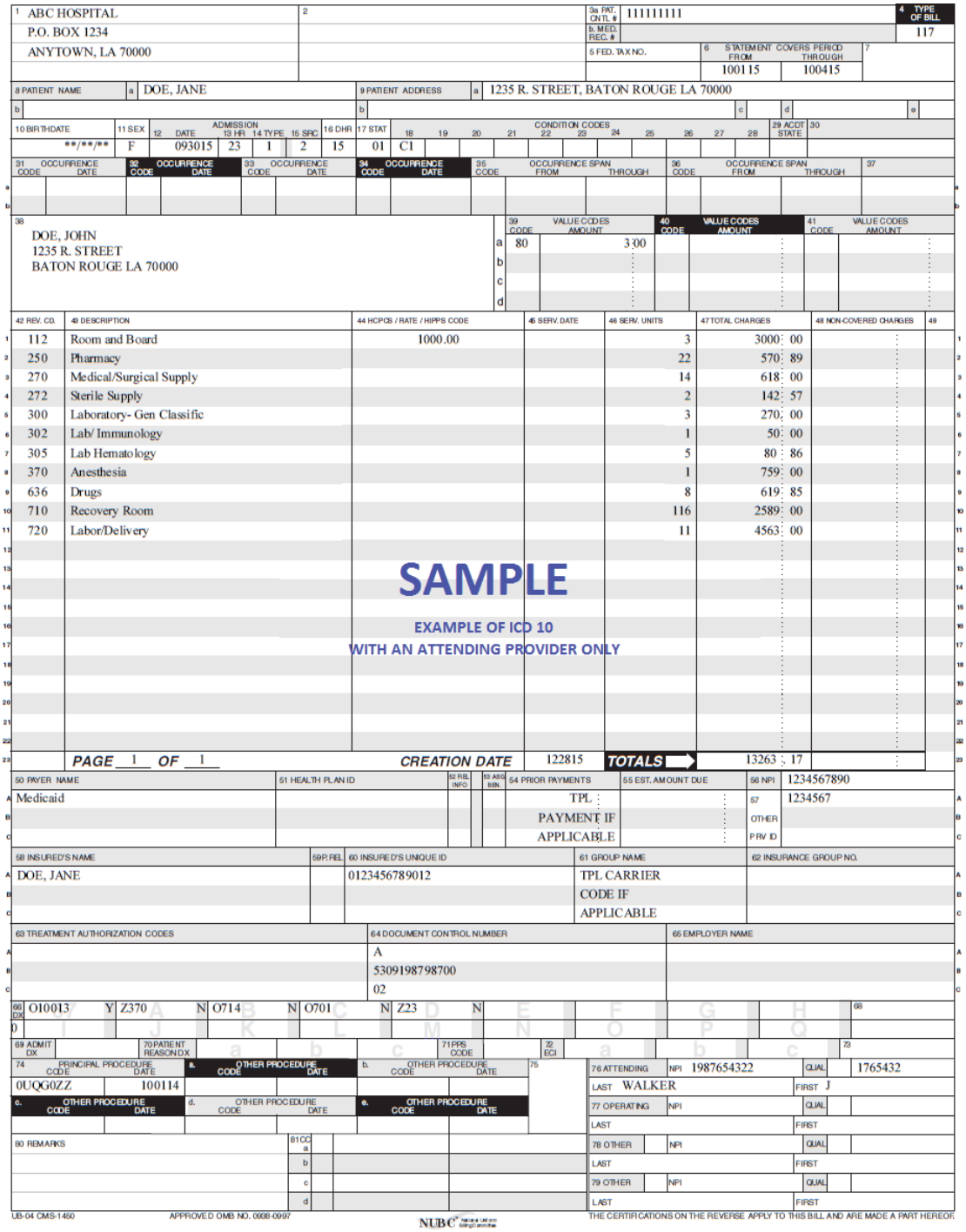
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
74 PRINCIPAL PROCEDURE CODE 0UQG0ZZ DATE 120216
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1987654322 QUAL 1765432 LAST WALKER FIRST J
77 OPERATING NPI QUAL LAST FIRST
78 OTHER DN NPI 1589999999 QUAL LAST DOE FIRST APRIL
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample inpatient hospital claim form adjustment with an attending provider only (with ICD-10 diagnosis code dates on or after Oct. 1, 2015) ~~SAMPLE INPATIENT HOSPITAL CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY (WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)~~



1 ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000	2	3a PAT. CNTL # 111111111 b. MED. REC. #	4 TYPE OF BILL 117
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 100415

8 PATIENT NAME	9 PATIENT ADDRESS
a DOE, JANE	a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES	29 ACDT STATE	30
//**	F	093015	23	1	2	15	01	C1		

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a						a
b						b

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
DOE, JOHN 1235 R. STREET BATON ROUGE LA 70000	a 80 3:00		
	b		
	c		
	d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	112	Room and Board	1000.00		3	3000 00		1
2	250	Pharmacy			22	570 89		2
3	270	Medical/Surgical Supply			14	618 00		3
4	272	Sterile Supply			2	142 57		4
5	300	Laboratory- Gen Classific			3	270 00		5
6	302	Lab/ Immunology			1	50 00		6
7	305	Lab Hematology			5	80 86		7
8	370	Anesthesia			1	759 00		8
9	636	Drugs			8	619 85		9
10	710	Recovery Room			116	2589 00		10
11	720	Labor/Delivery			11	4563 00		11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE 1 OF 1	CREATION DATE	122815	TOTALS	13263 17		23

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890
A Medicaid				TPL		57 OTHER PRV ID	1234567
B				PAYMENT IF			
C				APPLICABLE			

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JANE		0123456789012	TPL CARRIER	
B			CODE IF	
C			APPLICABLE	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
	A	
	5309198798700	
	02	

66 DX	A	B	C	D	E	F	G	H	68
0	O10013 Y	Z370 N	O714 N	O701 N	Z23 N				
	I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

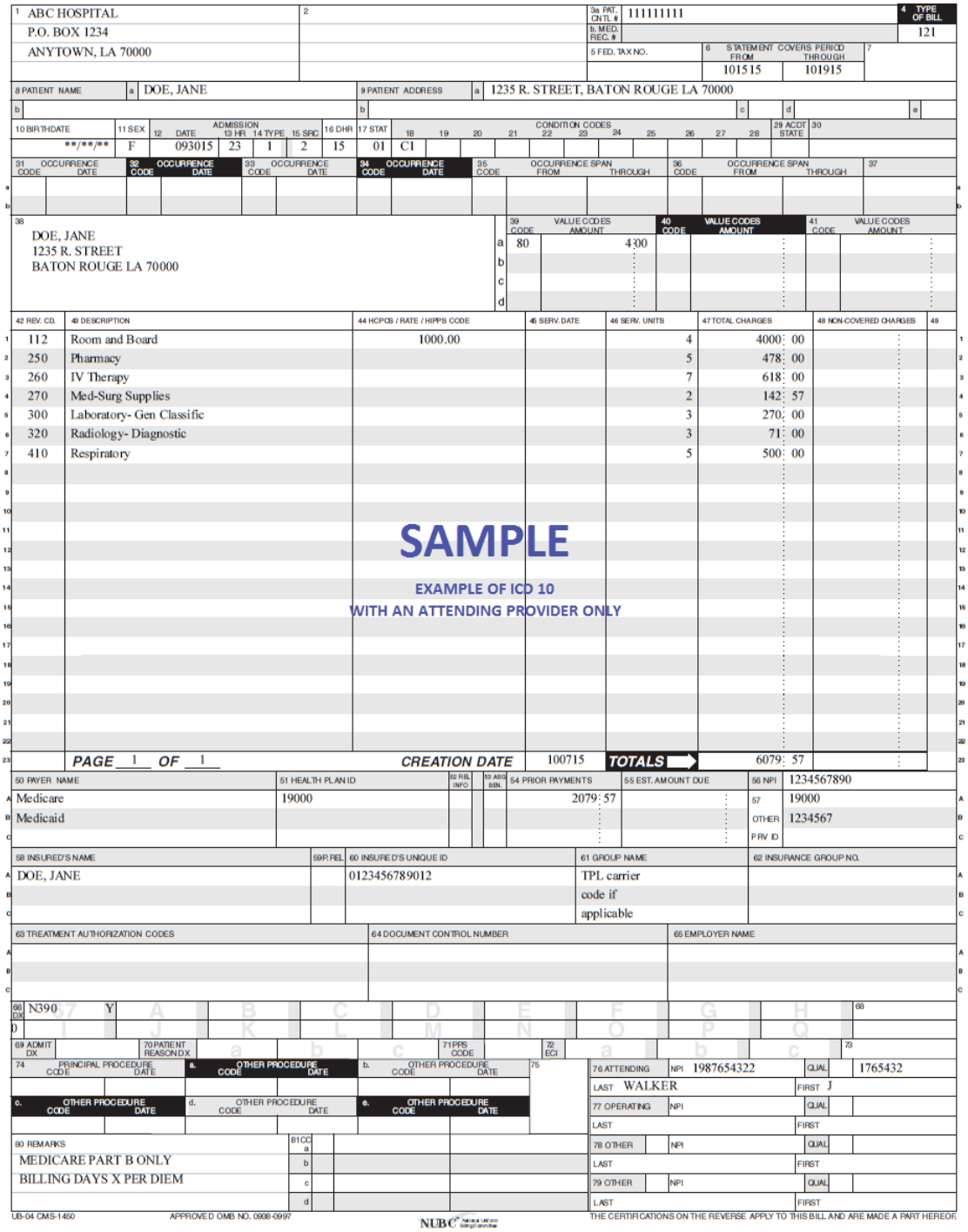
74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
0UQG0ZZ 100114			
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI 1987654322	QUAL	1765432
LAST WALKER		FIRST J	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81 CC	
	a	
	b	
	c	
	d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample inpatient hospital days x per diem claim form with an attending provider only (with ICD-10 diagnosis code dates on or after Oct. 1, 2015) ~~SAMPLE INPATIENT HOSPITAL DAYS X PER DIEM CLAIM FORM WITH AN ATTENDING PROVIDER ONLY (WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)~~



1 ABC HOSPITAL P.O. BOX 1234 ANYTOWN, LA 70000	2	3a PAT. CNTL # 111111111 b. MED. REC. #	4 TYPE OF BILL 121
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 101515 THROUGH 101915

8 PATIENT NAME	9 PATIENT ADDRESS
a DOE, JANE	a 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
//**	F	093015	23	1	2	15	01	C1		

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a						a
b						b

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
DOE, JANE 1235 R. STREET BATON ROUGE LA 70000	a 80 4:00		
	b		
	c		
	d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	112	Room and Board	1000.00		4	4000: 00		1
2	250	Pharmacy			5	478: 00		2
3	260	IV Therapy			7	618: 00		3
4	270	Med-Surg Supplies			2	142: 57		4
5	300	Laboratory- Gen Classific			3	270: 00		5
6	320	Radiology- Diagnostic			3	71: 00		6
7	410	Respiratory			5	500: 00		7
8–22								8–22
23		PAGE 1 OF 1	CREATION DATE	100715	TOTALS	6079: 57		23

SAMPLE

EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890
A Medicare	19000			2079: 57		57	19000
B Medicaid						OTHER PRV ID	1234567
C							

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JANE		0123456789012	TPL carrier	
B			code if	
C			applicable	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX	67	A	B	C	D	E	F	G	H	68
0	N390 Y	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75

c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE

76 ATTENDING	NPI 1987654322	QUAL	1765432
LAST WALKER		FIRST J	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81 CC		
MEDICARE PART B ONLY	a		
BILLING DAYS X PER DIEM	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

~~9_1definition_of_addiction_long_4-11.pdf.," , last accessed April 9, 2024, ..2024. :. Washington, DC: Press.~~