2023 Provider Manual

Humana Healthy Horizons® in Louisiana is a Medicaid product of Humana Health Benefit Plan of Louisiana Inc.

Humana
Healthy Horizons®
in Louisiana

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CHAPTER 1: WELCOME

Thank you for becoming a participating provider with Humana Healthy Horizons in Louisiana. 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 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 Managed Care Organization (MCO), Humana 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 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
- Grievance 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 you have questions or need help, go to Humana.com/HealthyLA or call us at **<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 2022, more than 1.8 million Louisiana residents were enrolled with a 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:
  - maximize member health
  - advance health equity
  - address 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 Policies and Procedures

According to Louisiana Act 319, any policy or procedure proposed by Humana 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 Act considers a "policy and procedure" to include any guidelines describing:

- billing
- medical management and utilization review
- case management
- claims processing
- grievance and appeals
- other 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 are prohibited from enforcing any policy or procedure that is not adopted in compliance with public comment period and procedures detailed in Act 319.

CHAPTER II: COMMUNICATING WITH HUMANA

By phone (all operating hours in local time):

Provider and Medicaid Member Service: <**800-448-3810**> **(TTY: 711)** Monday through Friday, 7 a.m. – 7p.m.

24-hour Nurse Advice Line (24/7/365): 800-648-7857

Behavioral Health Crisis Line (24/7/365): <833-801-7354>

Clinical Intake Team (CIT) for medical procedures and behavioral health: <888-285-1113> (TTY: 711)
7 a.m. – 7 p.m., Monday – Friday

Care management: <800-448-3310> (TTY: 711)
8 a.m.- 5 p.m., Monday – Friday

Prior authorization for pharmacy drugs: insert SBPM info

Member grievance and appeals: <800-448-3810>;
7 a.m. – 7 p.m., Monday – Friday

Provider complaints: <800-448-3810>; 7 a.m. – 7 p.m., Monday – Friday

Availity Essentials customer service/tech support: 800-282-4548; 8 a.m. – 8 p.m., Monday – Friday

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

Louisiana Medicaid Fraud and Abuse Hotline: <800-488-2917> (TTY: <800-220-5404>)

Humana fraud, waste and abuse reporting: <800-614-4126>

By mail:

Claims
Humana Inc.
P.O. Box 14822
Lexington, KY 40512-4822

Correspondence
P.O. Box 14822
Lexington, KY 40512-4822

Member Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

Fraud, Waste and Abuse
1100 Employers Blvd.
Green Bay, WI 54344

Provider Complaints
P.O. Box 14822
Lexington, KY 40512-4822

Helpful websites

Humana.com
Humana 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 Practice Guidelines (CPG)
- Provider publications (including handbooks, newsletters, program updates)
- Pharmacy services
- Claim resources
- Quality resources

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

Provider portal
Humana has partnered with Availity Essentials to give providers access to member and claim data for multiple payers using one login. Availity Essentials offers access to:

- Member eligibility and benefits
- Prior authorizations
- Claim status
- Claim submission
- Appeals and disputes submission
- Remittance advice
- Staff rosters of credentialed and contracted providers of mental health rehabilitation services
- Education and training materials including the Humana Louisiana Medicaid provider manual
- Member MCO care plans and health needs assessments

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

CHAPTER III: PROVIDER SERVICES

Primary care providers (PCPs)

The PCP shall serve as the member's initial and most important point of interaction with the contractor's provider network. A PCP shall be an individual physician, nurse practitioner or physician assistant who accepts primary responsibility for the management of a member's healthcare. The primary 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.
- Please refer to Chapter 3 Provider Services and Chapter 4 Covered Services and Behavioral 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 days a week
- Have hospital admitting privileges or a formal referral agreement with a primary care provider who has hospital admitting privileges

In addition, Humana 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 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; communicating with all other levels of medical care to coordinate and follow up the care of individual patients.
- 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.
- Development 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
- 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 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 network.
- Following all referral and prior-authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of Humana 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' specifications.
- Obtaining patient records from facilities visited by Humana 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 early and periodic screening, diagnostic and treatment (ESPDT) for persons younger than 21.
- Recommending referrals to specialists, as required.
- Participating in the development of care management and treatment plans and notifying Humana 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.
- Understanding that all network hospitals are required to comply with the data submission requirements of La R.S. 40:1173.1 through 1173.6. including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:II.105). The MCO shall encourage the use of Health Information Exchanges (HIE) where 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 days a week and shall not discriminate against members. Members should be triaged and provided appointments for care within the time frames below.

Medical Care:

Provider/Facility Type	Standard
Emergencies and Urgent Care	
Emergency Care	24 hours, 7 days/week within 1 hour of request
Urgent Non-emergency Care	24 hours, 7 days/week within 24 hours of request
Primary Care	
Non-Urgent Sick	72 hours
Non-Urgent Routine	6 weeks
After-Hours, by phone	Answer by live person or call-back from a designated medical practitioner within 30 minutes
Prenatal Visits	
1st Trimester	14 days
2nd Trimester	7 days
3rd Trimester	3 days
High risk pregnancy, any trimester	3 days
Family Planning	1 week

Provider/Facility Type	Standard
Specialty Care	
Specialist Appointment	1 month
Waiting Room Time	
Scheduled Appointments	<45 minutes
Accepting New Patients	
The practitioner office is open to new patients	Provider is listed in directory and/or registry file as open

Behavioral Health care:

Provider/Facility Type	Standard
Specialized Behavioral Health Providers	
Non-Urgent Routine	14 days
Urgent Non-emergency Care	24 hours
Waiting Room Time, scheduled appointments	<45 minutes
Psychiatric Inpatient Hospital (emergency involuntary)	4 hours
Psychiatric Inpatient Hospital (involuntary)	24 hours
Psychiatric Inpatient Hospital (voluntary)	24 hours
American Society of Addictive Medicine (ASAM) Level 3.3, 3.5 & 3.7	10 business days
Withdrawal Management	24 hours when medically necessary
Psychiatric Residential Treatment Facility (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 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.com;
- Visit members daily when 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 members should not be treated differently than patients with other healthcare insurance.

<Virtual visits or telehealth>

Integrated telehealth services

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

Family Planning

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.

These services include:

- Comprehensive medical history and physical exam at least once per year. This visit includes anticipatory guidance and education related to enrollees' 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 Food and Drug Administration;
- 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 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 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 Non-Emergency Medical Transportation (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

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.

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 all training programs 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.

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

- General Compliance (Ethics Every day and Compliance policy)
- Fraud, waste and abuse
- Medicaid provider orientation 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 Medicaid required topics.

The 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 will receive Humana's Medicaid provider orientation.

Providers and their office staff members can access these online training modules 24/7 at Humana.com/providercompliance.

For additional provider training: Visit Humana.com/providers, select Medical Resources and choose "Web-based Training Schedule" under "Education and News."

Department of Children 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 is contracted according to the following:

- If providers choose to display MCO participation stickers, they must display stickers by all contracted MCOs.
- Provider MCO Participation stickers cannot be larger than 5 by 7 inches or include any information other 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 provider who has 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 patient. 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.

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

- Providing Humana 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 members for a 60-day period following notification.
- Providing 24-hour availability to your Humana-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 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 and only recommends emergency room 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.

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 determination regarding claim payment. Our appeal process is outlined in the Grievance 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:

- 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 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 is involved

Humana will assure providers complete and submit adverse incident reports within one business day of discovery of the incident.

If appropriate, Humana and providers must report allegations of abuse, neglect, exploitation or extortion directly and immediately to the appropriate protective services agency or licensing agency. The following agencies are responsible for investigating such allegations:

- Department of Child and Family Service (DCFS)
- Adult Protective Services (APS) for vulnerable individuals ages 18 to 59
- Governor's Office of Elderly Affairs Elderly Protective Services (EPS) for vulnerable individuals ages 59 and older; and
- LDH Health Standards Section (HSS) for people who reside in a public or private Intermediate Care Facility, persons with developmental disabilities (ICF/DD), ICF/ Nursing Facilities, and Child Protective Services (CPS) 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.

The following are types of adverse incidents:

- Abuse (child/youth) - any one of the following acts that seriously endanger the physical, mental, or emotional health and safety of the child. 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 by the parent of 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 laws of this state. (La. Ch. Code art. 603(2))
- Abuse (adult) - the infliction of physical or mental injury, or actions which 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. (La. R.S. 15:1503.2)
- Death - 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) - the illegal or improper use or management of the funds, assets, or property of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage. (La. R.S. 15:1503.7)
- Extortion (adult) - the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:503.8)
- Neglect (child/youth) - the 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 prenatal illegal drug exposure caused by the parent, resulting in the Newborn being affected by the drug exposure and withdrawal symptoms. (La. Ch. Code art. 603(18))
- Neglect (adult) - the 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 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. (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 extenders who act as a primary care provider or those who appear in the provider directory

Behavioral health practitioners:

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's degree-level psychologists who are state-certified or licensed
- Master's degree-level clinical social workers who are state-certified or licensed
- Master's degree-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state-certified or licensed
- Other behavioral health specialists who are licensed, certified or registered by the state to practice independently, including licensed art therapists
- Unlicensed behavioral health providers are monitored through education and training verification

Humana conducts credentialing and recredentialing activities utilizing the guidelines established by the Louisiana Department of Health (LDH), the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Humana credentials and recredentials all licensed independent practitioners including physicians, facilities and non-physicians with which it contracts and fall within its scope of authority and action within 60 calendar days of receipt of a completed application. Through credentialing, Humana verifies the qualifications and performance of physicians and other healthcare practitioners. A senior Humana 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 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 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 Join the Healthy Horizons in Louisiana Provider Network

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

- Medical providers – LAMSProivderIntake@Humana.com
- Behavioral Health providers – LABHMedicaid@Humana.com

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

- Physician, Practice and/or Facility name
- Service address with phone, fax and email information
- If different from the service location, please include the mailing address
- Taxpayer identification number (TIN)
- Practicing specialty
- Louisiana Medicaid provider number, including the registered provider and specialty type codes
- National Provider Identifier (NPI)
- Type of contract type you are requesting
  - Individual
  - Group
  - Facility

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

- Credentialing application
  - Individual practitioners will be asked for your Council for Affordable Quality Health Care (CAQH®) number. Please ensure your CAQH® application and supporting documents are current. Please ensure you've granted Humana access to your application.
  - Facilities will be asked to complete Humana's Organizational Provider Assessment Form and include supporting documentation applicable to your provider type.
- Proof of current insurance coverage
  - Professional liability insurance coverage; or
  - Louisiana Patient Compensation Fund
- Disclosure of Ownership

Humana will acknowledge we've received 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, we will notify you in writing within thirty (30) days calendar days. 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@Humana.com
- Physical Health providers: LAMSProviderIntake@Humana.com

CAQH application

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

- Log onto the CAQH website at proview.caqh.org using your account information
- Select the Authorization tab
- Confirm Humana Healthy Horizons in Louisiana is listed as an authorized health plan; if not, please click 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 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 six months or greater
- Clinical Laboratory Improvement Amendment (CLIA) certificate, as applicable
- Copy of collaborative practice agreement between an advanced registered nurse practitioner and supervising practitioner
- Educational Commission for Foreign Medical Graduates (ECFMG), if foreign medical degree

Failure to submit a complete application may result in a delay in our ability to 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 five-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 physicians, 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
  - Medicare program
  - Health & Human Services Office of Inspector General (HHS-OIG)
  - General Services Administration (GSA, formerly Excluded Parties List System/EPLS)
- Healthcare providers must be screened by and enrolled with LDH to be considered for participation
- Active and valid Louisiana Medicaid ID number
- 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 group ownership

Organizational credentialing and recredentialing

Organizational providers assessed for credential award include, but are not limited to:

- Hospitals
- Home health agencies
- Skilled-nursing facilities
- Free-standing ambulatory surgery centers
- Hospice providers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Dialysis centers
- Physical, occupational therapy and speech-language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals including outpatient locations
- Diabetes education

- Portable X-ray suppliers
- Rural health clinics and federally qualified health centers
- School-based health clinics
- Local parish health clinics
- Indian healthcare providers

The following elements are assessed for organizational providers:

- Confirmation of the organization's good standing with:
  - Medicaid agencies
  - Medicare program
  - Health & Human Services-Office of Inspector General (HHS-OIG)
  - General Services Administration (GSA, formerly EPLS)
- Organization has been reviewed and approved by CMS or an accrediting body
- Copy of facility's state license, as applicable
- CLIA certificates are current, as applicable
- Completion of a signed and dated application
- Organizational providers are reassessed at least every three years
- Completed disclosure of ownership form

Provider recredentialing

Network providers, including practitioners and organizational providers, are recredentialed at least once every three years. In accordance with La. R.S. 46:460.72(B), providers are sent at least three written notices and given at least six months' notice of their recredentialing due date. As part of the recredentialing process, Humana also examines performance information regarding complaints, safety and quality issues collected through the quality improvement program. Additionally, information regarding adverse actions is collected from the NPDB, Medicare and Medicaid Sanctions, CMS Preclusion list, the HHS/OIG and GSA (formerly EPLS) and limitations on licensure.

Exemption from MCO Credentialing and Recredentialing

In accordance with La. R.S. 46:460.61, 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 will track providers who were credentialed by a hospital, FQHC or RHC, including the expiration and/or termination of privileges and/or employment. Upon 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 will follow the standard process for credentialing a new provider.

Provider rights

- Practitioners have the right to review, upon request, information submitted to the Humana Credentialing department in support of his or her 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 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 is notified and given the opportunity to correct information prior to presentation to the credentialing committee.
- Practitioners 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. 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 will initiate immediate action if the participation criteria are no longer met.

Network providers are required to inform Humana 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

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 a NCQA-accredited credentials verification organization (CVO) 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 will be 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 and CMS. Monthly reporting will be required from the delegated entity, which will be defined in an agreement between both parties.

Reconsideration of credentialing and recredentialing decisions

Humana'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 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, MD
Regional Medical Director
101 E. Main St.
Louisville, KY 40202

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 decision. Reconsideration denials are final unless the decision is based on quality criteria 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 CHIP. 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 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, 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 affects their status for more than 30 days are offered an opportunity for a fair hearing that entails an additional physician panel review of the action.

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 the Plan is able to provide the service through an in-network or out-of-network provider at a lower level of care.

Delegated services, policies and procedures

Scope

The guidelines and responsibilities outlined in this appendix are applicable to all contracted Humana delegated entities (delegate). The policies in Humana'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 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, facilities and other healthcare providers
- Provision of clinical health services, such as utilization management 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 **<800-448-3810>**.

Delegated providers must comply with the responsibilities outlined in the Delegated Services, Policies and Procedures section of this manual. The document is available from the local Humana market office, or by calling **<800-448-3810>**.

Oversight

Although a health plan can delegate the authority to perform a function, it cannot delegate the responsibility or accountability for making sure that the function is performed in an appropriate and compliant manner. Since Humana 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 their 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 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 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 continue to monitor all delegated entities through the collection of periodic reporting outlined within the delegation agreement. Humana Healthy Horizons in Louisiana will provide 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 provide a written response describing how they will meet the requirements found to be noncompliant including the expected remediation date of compliance.

Humana Healthy Horizons in Louisiana will cooperate with the delegate or its subcontractors to correct any failure. Any failure by the delegate to comply with 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'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 comply with the following requirements:

- Submit any material change in the performance of delegated functions to Humana for review and approval, prior to the effective date of the proposed changes.
- If required by state and/or federal law, rule or regulation, obtain and maintain, in good standing, a third-party administrator license/certificate and or a utilization review license or certification.
- Ensure that personnel who carry out the delegated services have appropriate training, licensure and/or certification.
- Adhere to Humana'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 changed or additional offshore locations or functions. Delegate must provide Humana Healthy Horizons in Louisiana with documentation of the pre-delegation audit that 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 United 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: Certain states may prohibit Medicaid protected health information from leaving the United States or 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 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 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. The delegate must provide Humana 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. 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 delegate finds that a provider, subcontractor or employee is excluded from any federal and/or state government program, they will be removed from providing direct or indirect services for Humana members immediately.

Appeals and grievances

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:

- Forward all standard member appeals/grievances to Humana within one business day [Phone: **<800-448-3810>** Fax: **<800-949-2961>**].
- Forward all expedited appeals immediately upon notification/receipt [Phone: **<800-448-3810>** Fax: **<800-949-2961>**]. When faxing, delegate will provide the following information: date and time of receipt, member information, summary of the appeal or grievance, all denial information, if applicable, and summary of any actions taken, if applicable.
- Promptly effectuate the appeal decision as rendered by Humana and support any requests received from Humana 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 claims payment and denials.

Utilization Management Delegation

Delegation of utilization management (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.

UM Requirements: Delegate is to conduct the following functions regarding initial and expedited/urgent determinations

- Maintain policies and procedures that address all aspects of the UM 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 performs this function when review decisions by delegate are not timely, are contrary to medical necessity criteria and/or when Humana Healthy Horizons in Louisiana must resolve a

disagreement between delegate, providers and member. In some local health plans, Humana may assume total responsibility for this function. Refer to your delegation agreement for specifics.

- For concurrent review activities relevant to inpatient and skilled nursing facility (SNF) stays, 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. Delegate is also responsible for conducting retrospective reviews for outpatient/ambulatory care.
- Perform UM activities for out-of-service areas and out-of-network providers as dictated by contract.
- Notify member, facility and provider of decision on initial determinations using Humana Healthy Horizons in Louisiana/CMS approved letter templates.
- If delegate is delegated for both utilization management and claims payment, the delegate may utilize Humana's prior authorization list (PAL) or develop their own PAL. However, the delegate's PAL may not be more stringent than Humana's PAL. If the delegate is not delegated to process claims on Humana's behalf, delegate must utilize Humana Healthy Horizons in Louisiana's PAL.
- For all determinations, maintain log and submit as required by regulatory and accreditation organization requirements. Humana 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 UM files and supporting documentation are Humana's property. Should the contract between the delegate and Humana 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 UM files for Humana members.
- Provide applicable UM 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 standards. Any changes will be communicated to the delegate at such time.

Care management delegation

Delegation of care management must include:

Complex Case Management (CCM): CCM 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.

Delegate 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'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 delegate's funding. Refer to contract for funding arrangement details.

Claims performance requirements: All delegates performing claims processing 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. Delegate will need to meet, at a minimum, the following claims adjudication and processing requirements:

- Delegate must accurately process at least 95% of all delegated claims according to Humana Healthy Horizons

in Louisiana requirements and in accordance with state and federal laws, rules and regulations and/or any regulatory or accrediting entity to whom Humana Healthy Horizons in Louisiana is subject
- Delegate 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 claims processing, such as a letter of credit, to ensure its continued financial solvency and ability to adjudicate and process claims. The 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 claims 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 Standards and Guidelines for the Accreditation of Medicaid Managed 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.

Humana Healthy Horizons in Louisiana is responsible for the collection and evaluation of ongoing monitoring of sanctions and complaints. In 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 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, 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. Delegate 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 IV: COVERED SERVICES

General services

Humana is required to arrange, through its contracted providers, the following medically necessary services for each member:
- Allergy testing and allergen immunotherapy
- Ambulatory surgical services
- Anesthesia
- Applied behavioral analysis therapy (age 0-20)
- Audiology services
- Bariatric surgery
- Breast surgery
- Chiropractic services (age 0-20)
- Cochlear implant (age 0-20)
- Diabetes self-management training
- Doula Services
- Durable medical equipment, prosthetics, orthotics and certain supplies
- Early periodic screening, diagnostic and treatment (EPSDT) services (age 0-20)
- Emergency services
- End-stage renal disease services
- Eye care and vision services
- Family planning services
- Federally qualified health center (FQHC)/rural health clinic (RHC) services
- Genetic testing
- Glasses, contacts and eyewear
- Gynecology
- Home health-extended services (age 0-20)
- Home health services
- Hospice services

- Hospital services
- Inpatient hospital services
- Outpatient hospital services
- Hyperbaric oxygen therapy
- Immunizations
- Intrathecal baclofen therapy
- Laboratory and radiology services
- Limited abortion services
- Medical transportation services
- Newborn care and discharge
- Obstetrics
- Pediatric day healthcare services (age 0-20)
- Personal care services (age 0-20)
- Pharmacy services
- Physician administered medication
- Physician/professional services
- Podiatry services
- Preventive services for adults (age 21 and older)
- Routine Care Provided to Enrollees Participating in Clinical Trials
- Sterilization
- Telemedicine/Telehealth
- Therapy services
- Tobacco-cessation services
- Vagus nerve stimulators

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

Behavioral health and substance-use services 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 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, medication management as well as treatment and referral to specialty services.
- Specialized behavioral health services:
  - Licensed practitioner outpatient therapy
    - 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) (age 0-20)
    - Functional family therapy (FFT) and functional family therapy-child Welfare (age 0-20)
    - Homebuilders® (age 0-20)
    - Assertive community treatment (age 18 and older)
      - Psychosocial rehabilitation (PSR)
      - Crisis intervention
      - Crisis stabilization (age 0-20)
  - Therapeutic group homes (TGH) (age 0-20)
  - Psychiatric residential treatment facilities (PRTF) (age 0-20)
  - Inpatient hospitalization (age 0-21; 65 and older)
  - Outpatient and residential substance use disorder services
  - Medication assisted treatment

Providers, members or other responsible parties can contact Humana Healthy Horizons in Louisiana at **<800-448-3810>** to verify available behavioral health and substance-use benefits and seek guidance in obtaining behavioral health and substance-use services.

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

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 Care Managers 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 health and substance use, as well as care management programs based upon member's level of need (see Chapter 10 Care Management Programs in this manual). Call **800-448-3310** to refer members needing care management assistance If you prefer, email LAMCDCaseManagement@Humana.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 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 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 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 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 transportation

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 she may call MediTrans at **<844-613-1638>**. Humana 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 and Non-emergency Ambulance Transportation providers shall pick up members no later than three hours after notification by an inpatient facility of a scheduled discharge or two hours after the scheduled discharge time, whichever is later.>

Excluded services

Humana 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'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 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 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
- Services to individuals in Intermediate Care Facility for Individuals with Development Disabilities ICF/IDDs
- Personal care services for those 21 and older
- 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 lieu of service
- Individualized Education Plan (IEP) services, including physical therapy, occupational therapy, 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 Program (Individuals with Disabilities Education Act (IDEA), Part C Program Services)
- The following 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.

The following prohibited services are not Medicaid-covered services and shall 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 Secretary of LDH
- Cosmetic drugs, devices, procedures or equipment
- Assistive reproductive technology for treatment of infertility
- Elective abortions (those not covered in the Louisiana Medicaid State Plan) 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

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, 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.

Sterilization

In order for a claim to be considered for payment, Humana requires the following forms to be submitted with the claim:

- For a sterilization procedure – Form OMB No. 0937-0166, "Consent to Sterilization"; and
- For a hysterectomy – Form 96-A, "Acknowledgment of Receipt of Hysterectomy Information."

CHAPTER V: UTILIZATION MANAGEMENT (UM)

Utilization management 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 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. 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 department performs all UM 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 Care Management team are made, if needed.

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

Criteria

Humana Healthy Horizons in Louisiana currently uses Milliman Coverage Guidelines (MCG) and the American Society of Addiction Medicine (ASAM), nationally recognized, evidence-based clinical UM criteria as well as Humana 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 the provider portal. Providers 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.

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

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 Medical Director for further review and determination.

Access to staff

Providers can email the UM staff with any UM questions.

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

Please keep the following in mind when contacting UM staff:

- Staff is available Monday through Friday, 7 a.m. to 5 p.m., Central time.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff are available to respond to email inquiries regarding UM issues.
- Staff are accessible to answer questions about the 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 reviewer, please send an email to the appropriate email address above or call the telephone number listed above within five business days of the determination.

Referrals

Humana Healthy Horizons in Louisiana members can see any participating network provider, including specialists and inpatient hospitals. Humana 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.

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 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 is not able to pay claims for services provided to ineligible members.

All services that require prior authorization from Humana 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 will notify you of prior authorization determinations via a letter mailed to your address on file.

Concurrent/Inpatient Authorizations

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

Observation Authorization

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 the MCO as soon as reasonably possible for potential authorization of an extension of hours. If the member converts to an inpatient status, notification is required within one business day of the order to admit the member. The MCO and provider shall work together to coordinate the provision of additional medical services prior to discharge of the member as needed.

Prior authorization timeframes

Humana will make 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:

- All inpatient hospital service authorizations within two calendar days of obtaining appropriate medical information

- All Provider of Community Psychiatiric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) service authorizations within five calendar days of obtaining appropriate medical information in accordance with contract section 2.12.6.1.2
- All standard service authorization determinations shall 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 member, or the provider, requests the extension; 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 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 MCO determines, following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO 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 may extend the 72-hour time period by up to 14 calendar days if the member requests the extension or if the MCO 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 Service Authorization.

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 upon previous service authorization approval, unless the approval was based upon 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 and respite care require prior authorization; routine home hospice care does not require prior authorization)
- Inpatient rehabilitative services
- Organ/tissue/bone transplants
- Select durable medical equipment, regardless of amount, specifically:
  - All powered or customized wheelchairs
  - wheelchair rentals longer than three 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's comprehensive preauthorization and notification lists for multiple Humana 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 the plan as to whether the item or service will be covered.

Services that do not require prior authorization

Some services DO NOT require authorization by Humana Healthy Horizons in Louisiana. These services include but are not limited to:

- Emergency & Post-Stabilization Services
- Non-Emergent newborn deliveries
- Continuation of medically necessary services for members transitioning from other MCO's
- Crisis Stabilization
- EPSDT Screening and other appropriate immunizations/ vaccinations based on the Periodicity Schedules
- Dialysis
- All Preventive Services for Communicable Diseases and Family Planning Services

Requesting prior authorization

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

For pharmacy prior authorization information, refer to the Pharmacy section of this manual.

Medical

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

Visit the provider portal at Availity.com

- Access various prior authorization forms online at Humana.com/providers
- Email completed forms to CorporateMedicaidCIT@humana.com
- Fax completed prior authorization forms to **833-974-0059**
- Call **<800-448-3810>** 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 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 admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.
- If inpatient surgery is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs.
- If outpatient surgery is being requested, please include the date of surgery, name of surgeon and facility, diagnosis, procedure planned, and anticipated follow-up needs after discharge.

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 services provided to our members are medically necessary and appropriately provided. Humana conducts retrospective reviews to determine whether authorization will be granted for services rendered before a prior authorization for the services was 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 [**888-285-1113**] and following the appropriate menu prompts. You can also fax the request to [**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 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. 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 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 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, 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 <**800-448-3810**>.

Louisiana Medicaid Electronic Health Record (EHR) Incentive Payment Program

This program provides incentive payments to eligible professionals (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs) who have adopted (acquired and installed), implemented (trained staff, deployed tools, exchanged data), and/or upgraded (expanded functionality or interoperability) or AIU, certified EHR technology for 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 (ONC) for up to five remaining participation years.

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

- Enhancing 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 National Health Information Network (NHIN).
- Details about this program and registration instructions can be found at: https://www.lamedicaid.com/provweb1/EHR/EHRIndex.htm

Additional emergency department HIE requirements

Network emergency departments are required to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) emergency department visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and Care Management. The visit registry shall consist of three 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 pieces of information are commonly available through the Health Level Seven (HL7) ADT message standard and in use by most ED admission systems in use today across the country. This data shall be available in real time to assist providers and systems with up-to-date information for treating patients appropriately.

CHAPTER VI: CLAIMS AND ENCOUNTER SUBMISSION PROTOCOLS AND STANDARDS

Medical claims and behavioral health encounters

Healthcare providers shall 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 phone numbers:

Availity®	Availity.com	**800-282-4548**
WayStar	Waystar.com	**877-494-7633**
Trizetto	Trizetto.com	**800-969-3666**
Change Healthcare (formerly Emdeon)	Changehealthcare.com	**800-792-5256**
SSI Group	Thessigroup.com	**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 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 physician claims payments include an itemized accounting of individual payment claims featuring the member' name, the date(s) of service, procedure code(s), service units, reimbursement amounts and identification of the Humana entity.

NOTE: Humana does not pay – directly or indirectly – a physician as an inducement to reduce or limit medically necessary services to members. Humana also doesn't provide incentives, monetary or otherwise, for the withholding of medically necessary care.

Humana shall assume full responsibility for collections in the event of third-party liability.

For claim payment inquiries or complaints, please contact Humana Healthy Horizons in Louisiana customer service at **800-448-6262 (800-4HUMANA)** or your provider contracting representative. You also may visit Availity.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 may reject claims because of missing or incomplete information. Common rejection or denial reasons:
- Patient not found
- Insured subscriber not found
- Patient birthdate 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 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.

Clean claims 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 and individual professional claims should be submitted on the CMS-1500. Clean claims must be filed within the specified contractual time frame.

Clean claim criteria

Per Chapter 1 of the CMS Medicare Claims Processing Handbook, the criteria for clean claims are as follows:

- The required claim information can be found without having to contact the provider, the beneficiary or other outside source (i.e., within the claim documentation, through medical review or from the payment office). Please note: These claims are not included in contractor performance evaluation scoring.
- **A fiscal intermediary (FI)** refers to an entity or a private company that has a contract with CMS to determine and pay part A and some part B bills, (e.g., bills from hospitals, on a cost basis and to perform other related specified contractual functions.
- Claims not approved for payment by common working file (CWF) within seven days of the FI's original claim submittal for reasons beyond the carrier's, FI's or provider's control (e.g., CWF system/communication difficulties)
- **CWF out-of-service-area (OSA)** claims are defined as those where the beneficiary is not on the CWF host and CWF must locate and identify where the beneficiary record resides.
- Medical claims include appropriate medical evidence from the provider records in accordance with the carrier's or FI's instructions.
- Are developed on a post-payment basis
- Have all basic information necessary to adjudicate the claim, and all required supporting documentation

A clean claim is one that does not contain a defect, 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 claims 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 timeframe. The Humana Companion Guide outlines all the information for the required fields for clean claim submission. The guide can be found at: Humana.com-companion-guide

Appendix II 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.

CMS-1500 billing instructions

For instructions on how to fill out the CMS-1500 claim form, please visit: 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: https://www.lamedicaid.com/provweb1/billing_information/ub04instructions.htm

Claims processing time frames

Per our agreement with LDH, Humana's claim processing responsibilities include:

- Performance of an initial screening either to reject or accept the claim within five business days of receipt of the claim
- Processing either to pay or deny at least 90% of all clean claim 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 shall 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

Timely filing

Providers are required to file timely claims/encounters for all Medicaid services rendered. Timely filing is an essential component of Humana Healthy Horizons 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 the date of service. Encounter data, as applicable, must be submitted to Humana within 30 days from the date of service.

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

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

Claims overpayments

Providers must report to Humana any service claim overpayments for medical services rendered to Medicaid managed-care-plan members, in accordance LDH contract. Regardless of agreement specifics, 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 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 reports all overpayments to LDH Program Integrity within 60 calendar days from the date the overpayment was identified. These reports include all unsolicited provider refunds.

Suspension of Provider Payments

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 will send the provider a notice and appeal rights. Once the suspension period has ended, Humana will adjudicate any previously pended claims.

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

Electronic claims payment offers several advantages over traditional paper checks:

- Faster payment processing
- Reduced handbook processes
- Access to online or electronic remittance information
- Eliminates risk of lost or stolen checks

With EFT, your Humana claims 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: 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.com) features an ERA/EFT enrollment tool. To access the tool:

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

EFT payment transactions are reported with file format CCD+, a NACHA Automated Clearing House (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 delivers 5010 835 versions of all ERA remittance files that are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Humana 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.com.

NOTE: 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: 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.com for answers to any questions.

Incentive plans

Upon request, the physician 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, 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 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 Humana Services (DHHS), a provider shall:

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

Claim status

You can track the progress of submitted claims at any time through Availity Essentials at Availity.com. Claim status is updated daily and provides information on claims submitted in the previous 24 months. Searches by member ID number, 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 payment (EOP)

Explanations of payment (EOPs) are current claim status statements Humana 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.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 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 electronically received claims. Accordingly, we accept only HIPAA-compliant code sets (i.e., HCPCS, Current Procedural Terminology (CPT) and International Classification of Diseases (ICD-10). In addition, the CMS rules for Medicare and Medicaid coding standards are followed. Generally accepted commercial health insurance rules regarding coding and reimbursement also are used when appropriate. Humana strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

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

Humana 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's claims processing procedures will be 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. For example:
  - Two or more surgeries performed the same day
  - Two or more endoscopic procedures performed the same day
  - Two 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 claims processing procedures in our sole discretion based on our review of correct coding initiatives, national benchmarks, industry stnadards, 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)
- American Hospital Association's (AHA) Coding Clinic 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 claims processing procedures may result in an adjustment or 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.

An adjustment in reimbursement as a result of claims processing procedures is not an indication that the service provided is a non-covered service. Providers can submit a dispute request of any adjustment produced by these claims processing procedures by submitting a timely request to Humana. For additional information, see Chapter VII: GRIEVANCE AND APPEALS of this manual.

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 upon use of certain codes, relationships between codes, unit counts or the use of modifiers. This review takes into consideration the previously mentioned state, Medicaid, CCI 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 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 upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Coordination of Benefits (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. 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 by:

- Member number
- Case number
- Medicaid number/MMIS number
- Member name and date of birth

You can check COB information for members who have been active with Humana within the past 12 months.

Crossover claims

Providers no longer need to send Medicare crossover claims for dually eligible recipients directly to Humana. Under this initiative, providers only need to submit their claims once to the Centers for Medicare & Medicaid Services (CMS) for processing and no longer are required to submit secondary claims to Humana. This means CMS will automatically forward claims for members who are dually eligible for both Medicare and Medicaid coverage. Please note: If a provider submits a claim for a dually eligible member that CMS already has forwarded to Humana, Humana will deny the provider-submitted claim as a duplicate claim. (As a side note this is only applicable for Original Medicare and not commercial Medicare Advantage plans).

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 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 that coverage for a payment determination before claims are submitted to Humana. 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 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 will provide 30-days written notice 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 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, they have 60 calendar days from when they receive the written notification to send a written response to Humana, explaining why the recoupment should not be put in place. When Humana receives a written response from a provider, Humana 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 recoups payment from a provider, the provider can either remit the amount to Humana or permit Humana 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.

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.

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 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 financial responsibility. The form or type of agreement must specifically state the services or procedures that are not covered by Medicaid.

Please call Humana Provider Services at **<800-448-3810>** 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 Meditrans at **<844-613-1638>**. Humana provides emergency transportation, as well as ambulance transportation, to and from medical appointments when a member must be transported on a stretcher and cannot ride in a car.

If you are concerned about a Humana Healthy Horizons in Louisiana member who misses appointments, please call Care Management Support Services at **<866-206-0272>**.

Member termination claim processing

From Humana to another plan:
If a member leaves Humana'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 in Louisiana will identify which members received a retro-eligibility date and require termination of enrollment within the Humana claims payment system.
2. Humana Healthy Horizons in Louisiana will initiate the member termination process. This will be completed within five 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 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 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 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:
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.

These items will be used to support exceptions to timely filing rules, if eligible. If a claim has exceeded timely filing due to retro-eligibility from another Medicaid plan, the provider has 90 days from the date of the accepted voided encounter to submit the claim to Humana Healthy Horizons in Louisiana to avoid timely filing denials.

Provider claim disputes

Providers can dispute specific claims or group of claims that have been denied or underpaid. Providers can submit claim disputes through any avenue, such as the Provider Customer Care unit, their Provider Relations representative, written correspondence via the Humana mailing address or the provider email address or the provider portal. Rendering providers can submit a dispute for those provider claims or group of claims that have been denied or underpaid within 180 calendar days of the payment notification.

Provider claim disputes will be:

- Resolved within 30 business days of receipt of the disputed claim.
- Reprocessed when the resolution determines the claim

paid or denied incorrectly, within 30 business days of receipt of the disputed claim.

A resolution letter will be sent to the provider within 30 business days of receipt of the claim dispute. The resolution letter will include:

i. The nature of the dispute;
ii. The claim dispute tracking number;
iii. A summary of the pertinent facts and claim detail for claim related disputes;
iv. The specific statutory, regulatory, contractual or policy references that support the resolution; and
v. Next steps if the provider disagrees with the resolution

A provider dispute may be filed using any of these methods:

Online

Provider disputes about finalized claims may be submitted online via Availity Essentials. To begin, sign in at Availity.com and use the Claim Status tool to locate the claim and click 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. Status and high-level Humana determination for disputes submitted online can be viewed in the Appeals worklist. For training opportunities, visit Humana.com/ProviderWebinars.

Phone

Providers can verbally submit a dispute by calling **<800-448-3810>** from 7 a.m. – 7 p.m., Central time, Monday – Friday.

Mail

Providers can submit disputes in writing via mail by using this address:

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

Or via an email to LAMedicaidProviderRelations@humana.com.

CHAPTER VII: COMPLAINTS AND APPEALS

There are several ways to work with us to resolve claims issues or disputes, based upon applicable state and federal regulatory requirements and your provider contract. Details of the provider dispute process are available through this provider manual and other channels including newsletters, training, provider orientation and face-to-face meetings or calls with your provider representative.

For the purposes of this section, the following definitions are provided:

- Provider complaint – A verbal or written expression by a provider, which indicates dissatisfaction or dispute with Humana Healthy Horizons in Louisiana's policy, procedure, claims processing and/or payment, or any aspect of Humana Healthy Horizons in Louisiana's functions.
- Adverse Benefit Determination – The denial or limited authorization of a requested service, including, but not limited to determinations based on:
  - The type of or level of service
  - Requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
  - The reduction, suspension or termination of a previously authorized service
  - The denial, in whole or in part, of a payment for a service
  - Failure to provide services in a timely manner, as defined by the state
  - Failure of Humana Healthy Horizons in Louisiana to act within the timeframes of the contract regarding the standard resolution of grievances and appeals
- Provider appeal – The formal mechanism which allows a provider to request review of Humana Healthy Horizons in Louisiana's final decision.
- Grievance – An expression of member dissatisfaction about any matter other than an Adverse Benefit Determination

Provider complaints

If a provider remains dissatisfied with the dispute determination, the provider may file a written complaint. Providers also may file complaints including, but not limited to, issues related to health plan staff, contracted vendors or formulary. Providers are allowed to file a written complaint with Humana within 90 days from the date of the occurrence. Within three business days, Humana will send a receipt acknowledgement letter that summarizes the complaint.

If the complaint requires research or input by another department, the Complaint System manager will forward the information to the affected department and coordinate with the affected department to thoroughly research the issue using applicable statutory, regulatory and contractual provisions and Humana's written policies and procedures, collecting pertinent facts from all parties.

The provider is offered a reasonable opportunity to present, in person or in writing, additional evidence and allegations of fact or law, if requested.

A decision will be made within 30 calendar days of receipt and the provider will be notified in writing. Humana Healthy Horizons in Louisiana will address provider complaints related to individual member attribution within 15 calendar days of receipt.

Providers may file a complaint by calling Provider Services at **<800-448-3810>** or writing to us at:
Humana Inc.
PO Box 14601
Lexington, KY 40512-4601

Provider appeals

Providers can file an appeal with Humana if a medical procedure or item provided to a Humana Healthy Horizons in Louisiana member is denied reimbursement due to lack of medical necessity or required prior authorization. Filing an appeal will not negatively impact the Humana member or treating providers.
A provider may file an appeal or request a state fair hearing on behalf of the member with the member's written consent, following the same steps identified here.

Provider requests to file an expedited appeal of a prior authorization denial for not-yet-rendered services will be transferred to the expedited member appeals process defined in the member section of this document. Expedited requests require written member consent for the provider to act on behalf of the member, and must meet expedited criteria, that waiting the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

Provider appeals will be decided within 30 calendar days of receipt of all necessary information, unless a time extension is warranted. The resolution period may be extended up to 14 calendar days if Humana shows that there is a need for additional information and that the delay is in the provider's best interest. If the resolution time frame is extended, Humana will send written notice of the delay within the original 30-day processing time frame.

NOTE: Non-participating providers are not eligible for this appeals process

Participating providers should follow the appeal process:

- The provider must submit the appeal request in writing within 60 calendar days of the notice of denial.
- The provider may submit the appeal request by telephone but is required to submit documentation in writing before the appeal process can start.
- 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. The appeal will be processed under the member's name.
- Additional or new clinical documents sent to Humana 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 by calling Provider Services at **<800-448-3810>** or writing to:
Humana Inc.
P.O. Box 14601
Lexington, KY 40512 4601

Independent review

The Independent Review process was established by La-RS 46:460.81, et seq. to resolve claims disputes when a provider believes an MCO has partially or totally denied claims incorrectly. The rendering provider must submit an appeal to Humana Healthy Horizons in Louisiana before requesting an independent review from LDH. If Humana Healthy Horizons in Louisiana upholds the adverse determination, then provider has 60 days to request an independent review from the Health Plan Management Department at LDH. Special Investigation Unit (SIU) post-payment reviews are not considered claims denials or underpayment disputes, therefore, SIU findings are exempt from the Independent Review Process.

Subject to review by LDH, providers may aggregate multiple adverse determinations involving Humana when the specific reason for nonpayment of the claims aggregated involve 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-step process.

Step One:
Submit a request for independent review reconsideration (IRR) to Humana Healthy Horizons in Louisiana within 180 days from one 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 of the request will be rendered within 45 calendar days, unless another time frame has been agreed upon in writing.

Step Two:
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 Independent Review 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

If the provider does not receive a decision within the 45 calendar day time frame, 60 days from the last day of the time frame (105 days from the date the IRR request was submitted to the MCO)

Providers can expect the following after requesting an independent review:

- LDH will determine eligibility for review
- The independent reviewer will contact providers within 14 days to request all information and documentation regarding the disputed claim or claims
- All information and documentation must be received within 30 days of the independent reviewer's request any information submitted by the provider that was not submitted to Humana as part of the appeal will not be considered by the independent reviewer.
- The independent reviewer will provide a resolution within 60 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 the independent reviewer renders a decision requiring Humana to pay any claims or portion of the claims, then Humana 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 for the fee associated with conducting an independent review when Humana's appeal decision is upheld.
- Within 60 days of the independent reviewer's decision, either the provider or Humana 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.

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:
LDH: Independent Review Request Form | La Dept. of Health

Providers can file an Independent Review Request in writing at:

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

Binding arbitration

You have the option to request binding arbitration for claims that have been denied or underpaid or a bundle of claims. The arbitrator must be certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If you and Humana 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 certifying association.

Arbitration conducted pursuant to this section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless you and Humana mutually agree to extend the deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties [RFP § 17.6.5]. Providers should review their contract with Humana for any specific language related to arbitration.

LDH 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 and phone number) so that LDH staff can follow up with any questions.

Member Grievance and Appeal system process

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

The Humana 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 has questions or an issue, he or she can call **<800-448-3810>** Monday through Friday, from 7 a.m. to 7 p.m. Central time. If dissatisfied with the answers from customer service, the member can file a grievance or appeal.

Members can call customer 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. If a member requests a form from Humana, it will be mailed within three working days. When filling out the form, the member can request help from Humana 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 days; however, Humana will resolve the member's grievance as quickly as his/her health condition requires. A letter explaining the outcome of the grievance will be sent within 90 days from 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 representation (AOR) required?	Yes
Is an acknowledgment of the grievance required?	Yes, within five 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 of the notice of adverse action. The date of the oral notice 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 days of the date Humana Healthy Horizons in Louisiana receives the request. The member has the right to review his/her 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 appeal is made is considered the date of receipt.
What is the time frame to submit the appeal?	Within 60 days from the date of the notice of adverse action
Is an appointment of representation (AOR) required?	Yes
Is an acknowledgment of the appeal required?	Yes, within five business days receipt of the appeal
What is the decision notification method?	Written
What is the decision time frame?	Appeal determinations should be rendered as 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 jeopordize the member's life, health, or ability to attain, maintain, or regain maximum function. The member or his/her 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 need to notify Humana that this is an "urgent" or "expedited" appeal. An expedited appeal may be made by calling **<800-448-3810>**. If it is determined that an expedited process is not required, then the appeal will go through the normal process.

NOTE: Humana 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 Fair Hearing

If a member is dissatisfied with Humana's appeal decision, he/she can ask for a State Fair Hearing. With the member's permission, and a signed consent form, providers may ask (on the member's behalf) for a State Fair Hearing from the Louisiana Department of Health.

A member may seek a State Fair Hearing after exhausting Humana's appeal process. A member who has exhausted Humana's appeal process may file a request for a State Fair Hearing within 120 calendar days of receipt of Humana'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: **225-219-9823**

By web: adminlaw.state.la.us/HH.htm

The member has the right to continue to receive benefits during a State Fair Hearing, 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.

CHAPTER VIII: QUALITY 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 **<800-448-3810> (TTY: 711)**.

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

Health records review – Conducted to meet requirements of accrediting agencies, federal and state law requirements. Annually, Humana may review a sample of clinical records for Humana members. Humana does not review all records and is not responsible for ensuring the adequacy or completeness of records.

HEDIS – A set of performance measures. Humana may conduct medical record reviews to identify gaps in care for Humana 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 submitted supplemental data. There are two primary routes for supplemental data – non-standard and standard.

Non-standard supplemental data – Involves directly submitting scanned images (e.g., PDF documents) of completed attestation forms and medical records. 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.

Standard supplemental data – Flows directly from one electronic database (e.g. population health system, EMR) 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 via either secure email or FTP transmission. We also accept lab data files in the same way. Humana partners with various EMRs to provide member summaries and detail reports and to automatically retrieve scanned charts.

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.

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

Member complaints – Member complaints and grievances pertaining to quality of care and concerns may be referred to the Quality Operations Department for review.

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

Initiate performance improvement projects (PIPs) 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, pharmacy 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 provider relations 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's lasting commitment to make a difference. Humana uses

HEDIS® as one measure of the quality of care delivered to Humana 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 also utilizes performance measures developed in collaboration with the state and the External Quality Review Organization (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.

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 organizations and focuses on preventive care, health screenings and prenatal care, as well as special populations.

Quality Assessment and Performance Improvement (QAPI) program

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

- Performance improvement projects
- Over- and under-utilization measures
- Annual analysis of plan clinical, 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
- 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

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 members.

Health record review

You may periodically receive requests for medical record copies for review from an EQRO or Humana Healthy Horizons in Louisiana. Your contract with Humana Healthy Horizons in Louisiana requires that you furnish member medical records to us for this purpose. EQRO reviews are a permitted disclosure of a member's personal health information 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 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 will review medical records to ensure the 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 provides medical and other clinical data required for Quality and UM Review

Humana will ensure the medical record includes 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 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
  - Initials of providers must be identified with correlating signatures
- Consider using preprinted forms to document all aspects of comprehensive services such as EPSDT exams

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 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 collection.

To learn more about Humana's value-based payment 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 policies and procedures.

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

- Formalizes Humana'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 policy; professional, ethical or legal standards; and fraud, waste and abuse concerns
- Allows Humana 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 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 call Provider Services at **<800-448-3810>**. We appreciate your commitment to compliance with ethics standards and reporting identified or alleged violations of such matters.

Fraud and abuse policy

Providers must integrate specific controls into their practice operations to help ensure prevention and detection of potential or suspected fraud and abuse. Provider staff 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 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 member ID card to obtain services or supplies from Humana 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 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 **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 **800-4HUMANA (800-448-6262)** and Louisiana's Medicaid Fraud and Abuse Hotline at **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: **800-614-4126** (24/7 access)
- Ethics Help Line: **877-5-THE-KEY (877-584-3539)**

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

Web: Ethicshelpline.com or Humana.com

CHAPTER IX: SPECIALIZED BEHAVIORAL HEALTH

Objectives of the Behavioral Health Program

Humana 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 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.

Our objectives are consistent with the overall Humana mission and vision of becoming a world-class leader in helping people achieve lifelong well-being. Humana 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 UM teams is an integral part of this care.

Our 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's UM, Care Management, and Population Health programs are integrated in our Model of Care. We work closely with the providers in our Humana network to ensure that these goals are met in a seamless manner with our members receiving the full support of their various providers and Humana support system.

Integration of behavioral health and medical care

Humana Healthy Horizons in Louisiana provides a comprehensive integrated care management model for our highest-risk members, 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 care coordination portal via Availity.com or request a copy by calling us at **800-448-3310**.

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 necessary signed release for sharing of personal health information, including compliance with 42CFR Part II 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, obtain signed release for sharing of personal health information, in compliance with 42CFR Part II requirements around SUD.
- Provide initial and quarterly summary reports to the PCP (after receiving above 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 Care Managers to join member's MDT, as appropriate and upon member request.

Continuity of care for behavioral health

For members receiving inpatient behavioral health services at any level of care, Humana requires providers to schedule an outpatient follow-up appointment prior to the member's discharge from the facility. The outpatient follow-up must be scheduled to occur within seven days from the date of discharge. Behavioral health providers are expected to contact patients within 24 hours of a missed appointment to reschedule.

Addiction

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. This condition is reflected through pathological reward pursuit and/or relief by substance use and other behaviors.

Addiction is characterized by:

- Inability to consistently abstain
- 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 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. Like 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. There are four major dimensions that support recovery:

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

Recovery-oriented care and support systems help people with SUDs 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 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 SUDs 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
- Medical devices and applications used to treat withdrawal symptoms or deliver skills training
- 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 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 abuse treatments almost exclusively prevents disclosures without the patient's consent.

More information about HIPAA and 42 CFR Part 2 can be at the following links:

- HIPAA - https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/PrivacyandSecurityInformation
- 42 CFR Part 2 - https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs

Provider expectations regarding OJJ and DCFS coordination

Coordinated system of care (CSoC)

The CSoC is designed to provide services and supports 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, 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.

CSoC qualifications:

- Behavior problems require the child to live elsewhere
- Child has tried to hurt himself or someone else
- Child is getting suspended and/or expelled from school
- Child has repeated run-ins with police

If you think CSoC might be right for one of your patients, or you want more information, call <XXX-XXX-XXXX>.

Payment for services Provided to CSoC recipients

CSoC-eligible members receive physical health, primary behavioral health and pharmacy coverage from Humana. Specialized behavioral health services will be covered by Magellan, except for psychiatric residential treatment facility (PRTF) services.

Humana is responsible for payment to enrolled providers for the provision of specialized behavioral health services for any month during that the recipient has a 1915(c)/1915(b)(3) segment on the eligibility file with a begin date later than the first day of that month. Humana is responsible for payment of all PRTF services.

Act 582

To be eligible to receive Medicaid reimbursement, all behavioral health service providers rendering PSR or CPST services must meet the requirements set forth in ACT 582. The following is a list of the requirements to become a service provider of PSR and CPST:

Provider agencies: To be eligible to receive Medicaid reimbursement, behavioral health service providers (BHSP) providing PSR or CPST to Medicaid recipients must meet all the following requirements:

- Be licensed as a BHSP agency.
- Be accredited by a department-approved accrediting organization.
- The behavioral health service provider must show proof of full accreditation or obtain preliminary accreditation prior to being contracted with a Medicaid MCO.
- The BHSP must maintain proof of continuous full or preliminary accreditation.
- Have a National Provider Identification number (NPI)
- The BHSP must include its NPI number and the NPI number of the individual rendering PSR or CPST services

on all PSR and CPST claims submitted for Medicaid reimbursement for dates of service on or after January 1, 2019.

- Implement a member choice form signed by each recipient or legal guardian or representative of the person receiving PSR or CPST.
- Be credentialed and in the Humana network unless the provider has a single case agreement. In such single case agreements, the BHSP agency must be both licensed and accredited.
- Employ at least one physician or licensed mental health professional (LMHP)-who works for the agency at least 35 hours per week-to serve as a full-time mental health supervisor who assists in the design and evaluation of treatment plans. For purposes of this requirement, LMHP is defined as one of the following fully licensed practitioner types able to practice independent of supervision:
  - Medical psychologist
  - Licensed psychologist
  - Licensed clinical social worker (LCSW)
  - Licensed professional counselor (LPC)
  - Licensed marriage and family therapist (LMFT) or
  - Licensed advanced practice registered nurse (APRN)
- Provide supervision for unlicensed individuals. The BHSP shall ensure each unlicensed individual rendering PSR or CPST services for their agency receives at least one hour a month of personal supervision and training by the agency's mental health supervisor.
- Meet all additional statute requirements found in the Medicaid Behavioral Health Services Provider Manual.

Individuals providing services

To be eligible to receive Medicaid reimbursement, BHSPs must ensure that any provider rendering PSR or CPST services for their agency meets all the following requirements:

- Have a National Provider Identification number (NPI). 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).
- Have a bachelor's degree from an accredited university or college in the specific field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, or human growth and development.
- Any bachelor's degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology.

Detailed information about these requirements can be found in the 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 monitors specialized behavioral health providers and facilities across all levels of care, incorporating on-site audits and member interviews. The reviews occur quarterly or as needed based on quality-of-care and/or billing concerns.

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 Medicaid Behavioral Health Services Provider Manual. Verification includes review of provider and staff personnel records and other administrative records and behavioral health treatment record review.

Treatment records must:

- Include accurate and legible information
- Be safeguarded against loss, destruction or unauthorized use
- Be maintained in an organized fashion and readily accessible for review or audit
- The treatment records must include, minimally, the following:
  - Member name or ID noted on each page of the record
  - Member demographic information including:
    - Name and date of birth
    - Gender
    - Address, phone, emergency contact
    - Guardianship information noted (for children), employment name and address, school (if applicable) and sexual identity
- Primary language spoken by the member and any translation needs of the member
- Treatment consent forms
- Member Bill of Rights
- Release-of-information forms for PCP and other involved parties
- Information provided about psychiatric advance directives, as appropriate

- Initial evaluation/assessment including:

Presenting problem and Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis	Mental health status exam and psychiatric history	Preliminary discharge planning	Assessment of co-occurring SUD
Suicide/risk assessment	Assessment of strengths, skills, abilities, etc.	Assessment of strengths, skills, abilities, etc.	Developmental history for children and adolescent
Family and social support assessment	Member's desired outcomes	Medical history, including allergies and adverse reactions	Current medication and dosages

- Individualized treatment plan including:
- Measurable goals and objectives with time frames for completion
- Member participation in treatment planning documented by member's signature
- Incorporation of preventive services and member education
- Progress notes including:

Documented treatment	Date, begin and end times of service	Documentation supports current level of care
Assessment of member's progress	Continuous substance use assessment, if applicable	Continuous suicide/risk assessment
Medication compliance (if applicable)	Family/support system involvement, preventive services recommended	Discharge planning for alternative or appropriate level of care (when applicable

- Individualized crisis plan
- Coordination of care to include PCP communication and coordination with other involved behavioral health providers, programs or institutions (if applicable)
- Documentation of medication management (if applicable) that includes Psychotropic Medication Consent and Prescription Monitoring Program Query forms
- Documentation of cultural competency
- Documentation of comprehensive discharge planning

Agency-specific requirements are based on level-of-care services delivery billed.
Audit elements may be found on Louisiana Department of Health's website at ldh.la.gov/index.cfm/page/1700

Humana Healthy Horizons in Louisiana initiates the appropriate corrective action when a provider or staff fails to meet quality standards and requirements, minimum provider qualifications or requirements, appointment availability standards, or is found to be out of compliance with contract provisions, federal and state regulations, law, rules, state plan amendment (SPA), waivers, the Medicaid Behavioral Health Services Provider Manual or 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.

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 programs operating with high fidelity produce positive consumer outcomes. Ongoing fidelity monitoring allows Humana to attribute consumer outcomes to interventions. Humana'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)
- Child Parent psychotherapy (CPP)
- Parent child interactive therapy (PCIT)
- Preschool and youth post-traumatic stress disorder (PTSD)
- Positive Parenting Program Standard Level 4 (Triple P L4)
- Trauma-focused cognitive behavioral therapy (TF-CBT)

The fidelity monitoring plan will assess 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.

CHAPTER X: MEMBER 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 daily via an 834 file for members assigned to Humana. Eligibility begins on the first day of eatch calendar month for members joining Humana, except for babies born to an eligible mother.

Newborn enrollment

Humana Healthy Horizons in Louisiana begins coverage of newborns on the date of birth when the newborn's mother is a member of a Humana Healthy Horizons in Louisiana plan. The newborn will appear on the PCP's member eligibility list after it is added to the Humana Healthy Horizons in Louisiana system.

You can verify eligibility for a newborn on the Availity Essentials Provider Portal at Availity.com.

New member kits

Each new member household receives a new member kit (including 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 ID card.

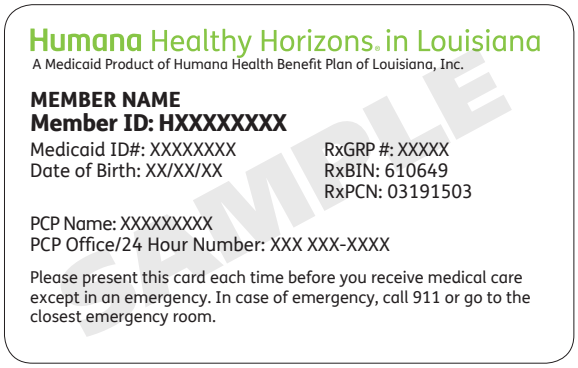
The new member kit contains:

- Welcome letter
- Information on how to obtain a copy of the Humana 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

All new Humana Healthy Horizons in Louisiana members receive an member ID card. A new card is issued only when the information on the card changes, 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.



Important things to know about the information provided on each member's Humana Healthy Horizons in Louisiana ID card:

FRONT:	BACK:
Humana Healthy Horizons in Louisiana Member ID: Use this number on claim	Behavioral Health Hotline: Members can call this hotline 24/7/365 for mental health or addiction services.
PCP Name/Phone: Each member chooses a participating provider to be his or her primary care provider. If no choice is made, Humana Healthy Horizons in Louisiana assigns a PCP.	Provider Portal: Our website contains plan information and access to special functionality, such as eligibility verification, claim and prior authorization submission, COB check 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'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 assignment

Humana will conduct periodic analytical reviews of PCP membership assignments to ensure members are appropriately assigned. The results of the analytical reviews will be shared with the PCP and the PCP will be given fifteen (15) days to dispute any membership assignments.

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 MCO
- MCO doesn't cover services requested by the member because of moral or religious objections
- Lack of access to MCO-covered services as determined by LDH

Humana 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 Care Management Department at **<800-448-3310> (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. Disenrollment from Humana 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, they are automatically re-enrolled in Humana and assigned to the same PCP, if possible. Please call Provider Services at **<800-448-3810>** 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 provider feels that his/her conscience, religious beliefs, or ethical principles require involuntary dismissal of the member as his/her 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 member services at **<800-448-3810>** 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 can assist members who have questions or concerns about benefits and services such as case or disease management.

Representatives are available by telephone at **<800-448-3810>** 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 Nurse Advice Line

Members can ask an experienced staff of registered nurses about health-related symptoms seven days a week, 365 days a year, by calling **<800-648-7857>**.

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:

- 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 mental 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. Members may call Humana's Member Services toll-free number at **<800-448-3810>** to get help in finding a provider.

Behavioral Health Crisis Hotline

For emergency behavioral healthcare within or outside the service area, please instruct members to go to the closest hospital emergency room or any other recommended emergency setting. They should contact you or Humana's Behavioral Health Crisis Line first if they are not sure the problem is an emergency. Humana's Behavioral Health Crisis Hotline is staffed by trained personnel 24 hours a day, seven 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 **<800-448-3810>**.

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 XI: MEMBER 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 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 members dignity and privacy
- To have a candid discussion of appropriate or medically necessary treatment options and alternatives in a manner appropriate to members' condition and ability to understand, regardless of cost or benefit coverage
- To participate in treatment decisions, including the right to:
  - Refuse treatment
  - Complete 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
  - Assistance 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.
- Express 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
- Receive 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
- Be furnished with health care services in federal regulations governing access standards
- Complete 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 right 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 can choose health professionals to the extent possible and appropriate under federal regulations
- Request a practitioner of the same race, ethnicity and/or language if there is a practitioner available in their network
- To receive health care services in accordance with all other applicable federal regulations
- To exercise the rights described herein without any adverse effect o member treatment by LDH, the MCO or its contractors or providers
- To make recommendations to the Member Rights and Responsibilities statement

Member responsibilities shall include, but are not limited to:
- Informing the MCO of the loss or theft of member MCO identification card
- Presentation of the member identification card when using health care services
- Protection of the member ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of Medicaid eligibility and/or legal action
- Familiarity 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
- Provide the information Humana Healthy Horizons and your healthcare providers need in order to care for you
- Follow the advice and instructions for care they have 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 immediately if member has a Workers' Compensation claim, a pending personal injury or medical malpractice lawsuit or 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: **888-342-6207**, Monday through Friday, 7 a.m. to 4:30 p.m. Central time
  Website: sspweb.lameds.ldh.la.gov/selfservice/
  Local offices:
  ldh.la.gov/index.cfm/directory/category/158

Personally identifiable information and protected health information

In the day-to-day business of patient treatment, payment and healthcare operations, Humana 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 Privacy Rule requires 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 Information page is at ldh.la.gov/index.cfm/page/131. The notice informs members about 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 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., HIV/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 Privacy Rules, Part 2 provides more stringent federal protections in an attempt to protect individuals with substance-use disorders 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 will display all member information on the provider portal at Availity.com and any health information exchanges. Please explain to your patients that if they do not consent to let Humana 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.

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, 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, 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 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-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 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 **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 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 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 committed to developing strategies that eliminate health disparities and address gaps in care.

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.

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 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 **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 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 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 Service at **800-4HUMANA (800-448-6262)** or call your provider contracting representative. The copy of Humana's Cultural Competency Plan will be provided at no charge.

Advance directives

PCPs are responsible for discussing advance medical directives 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 allows a member to make decisions related to their mental health treatment in advance. This includes but 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 valid if two physicians believe the member are incapacitated and unable to make an informed decision. The

document also allows the member to appoint a person as 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 XII: CARE MANAGEMENT PROGRAMS

Care management

Humana Healthy Horizons in Louisiana's Care Management Program 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, 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 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 to take an active role in your patient's care management program, participate in the development of a comprehensive care plan, and become part of an MDT.

Member plans of care and health needs assessments are viewable on Humana's provider portal and are available upon request by calling our care management team at **<800-448-3310>**.

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 from 8 a.m. to 5 p.m., Monday through Friday, Central time by calling **800-448-3310**, faxing to **833-981-0204** or emailing us at [LAMCDCaseManagement@humana.com]. 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, 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 care goals.

Care management for medium-risk members

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 and plan of care updates through in-person or telephonic outreach.

Transitional care management

Care management activities may integrate community health worker, peer or specialist support. Case managers focus on implementation of the member's plan of care, prevention of institutionalization and other adverse

outcomes, and supporting the member in self-managing their 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.
- Review of discharge instructions and medication changes

HumanaBeginnings®prenatal program

Humana's HumanaBeginnings Program provides perinatal and neonatal care management utilizing a specialized staff. 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 direct telephone contact with members and providers. We encourage our prenatal care providers to notify the Care Management team at **800-448-3310** 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 to **(833-982-0053)**.

CHAPTER XIII: POPULATION HEALTH PROGRAMS AND INCENTIVES

Population Health programs are offered to encourage and reward behaviors designed to improve a member's overall health. Programs administered by Humana 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 General (OIG). The following population health programs are offered to Humana'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 upon Humana 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 2022). This allows the member time to redeem their reward.

The Go365 for Humana Healthy Horizons mobile application 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
Breast cancer screening (40 and older)	$25 in rewards for female members who obtain a mammogram once per year.
Cervical cancer screening (21 and older)	$25 in rewards for female members who obtain a pap smear once per year.
Colorectal cancer screening (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 Humana plan may upload vaccination card within 90 days of enrollment to receive the reward. New members who were not vaccinated prior to enrollment in Humana, have 90 days from completion of vaccination and upload the vaccination card to receive the reward.
Diabetic retinal eye exam (18 and older)	$25 in rewards for diabetic members who complete a retinal eye exam once per year.
Diabetic screening (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.
Flu vaccine	$20 in rewards for members who receive an annual flu vaccine from their provider, pharmacy or self-reporting if they received a vaccine from another source.

Activity	Reward details
Health needs assessment (HNA)	$30 in rewards for members who complete their Health Needs Assessment (HNA) within 90 days of enrollment with Humana, one reward per lifetime.
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.
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 two opportunities where members can 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 Wellness Coaching calls (total 8) within 12 months of the first coaching session, one per year.
Weight management program (12 and older)	Enrollment in Weight Management Program, 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 two opportunities where members can earn rewards. <$30> in rewards: Enrollment in the Weight Management Program • 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 (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 per visit with a 2 visit limit.
Annual wellness visits (3 to 20)	$25 in rewards for members who complete 1 annual wellness visit.

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 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 **<800-448-3310>** 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 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 **<877-320-1235>**.

Health education

Humana members receive health information in various ways, including easy-to-read newsletters, brochures, phone calls and personal interactions. Humana also sends preventive care reminder messages via mail and automated outreach messaging.

CHAPTER XIV: VALUE-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 State Plan 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 State Plan and any Medicaid coverage and limitations handbooks.

Humana Healthy Horizons in Louisiana has committed to offering 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
Dental services (21 and older)	$500 annual allowance toward annual preventive services, exams, extraction and restorative services with in-network providers
Drowning prevention classes (0-21 years)	Drowning prevention classes are offered with the free YMCA membership. If the member does not reside within 20 miles of a partnering YMCA, the member is eligible for reimbursement of up to $200 annually for swimming lessons for infants and children from a certified swim instructor.
GED test preparation (16 and older)	GED test preparation assistance, including a bilingual advisor, access to guidance and study materials, and unlimited use of practice tests. Test preparation assistance is provided virtually to allow maximum flexibility for members. Also includes test pass guarantee to provide members multiple attempts at passing the test. 16 - 18 years: must provide additional documentation Underage test-takers: Underage testers must enroll in the state's official Adult Education Program 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.
Home-based interventions for asthma	Up to $200 once per year. Members with asthma can utilize this allowance towards carpet clearing, allergen free bedding and/or air purifier. Must have asthma diagnosis. Must be approved by a Care Manager .

Value added benefits	Description
Housing assistance (21 and older)	Up to <$500> per member per lifetime 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 Park and lot rent if this is your permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Must be approved by Care Manager. 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.
Meals-disaster preparedness/relief	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) allowance	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 - acupuncture services (21 and older)	Members suffering from chronic pain and/or opioid use disorder can take advantage of 24 acupuncture visits per year.
Pain management - chiropractic services (21 and older)	Members suffering from chronic pain and/or opioid use disorder can take advantage of 24 chiropractic 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.
Respite care for homeless program (males 18 and older)	The Medical Respite Program ensures member recovery and stabilization, successful member integration back into the community, and reducing unnecessary emergency department visits and hospital admissions.
Sports physical (6 – 18 years)	1 sports physical per year.
Vision services (21 and older)	1 eye exam per year Up to $100 allowance for 1 set of glasses (frames and lenses) or contacts, not both during the plan year. Member pays any cost over $100
YMCA membership	Free one-year membership at participating YMCA.

CHAPTER XV: Pharmacy

Effective July 1, 2022, All Louisiana Medicaid Managed Care Organizations (MCO), including Humana Healthy Horizons in Louisiana, will partner with one Pharmacy Benefit Manager (PBM, <insert name>, for pharmacy claims processing and pharmacy prior authorizations (PA).

All outpatient drugs, including OTC drugs, will be covered under a single Louisana formulary and preferred drug list (PDL) managed by <SBPM TBD>. This does not include physician administered drugs, which will continue to be managed by MCOs, under their medical benefit.

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 administers the LDH Preferred Drug List (PDL), which indicates either preferred or non-preferred status of covered drugs. The PDL also identifies drug utilization management requirements such as prior authorization, quantity limits and step therapies. Check the current formulary at Humana.com prior to writing a prescription to determine if the requested drug is covered.

Utilization Management (UM)

The PDL identifies covered drugs and associated drug UMrequirements, such as prior authorization, quantity limits, step therapy, etc.

- Prior authorization: the medication must be reviewed using a criteria-based approval process prior to coverage decision
- Step therapy: the member is required to utilize medications commonly considered first-line before using medications considered second- or third-line.
- Age/Quantity limits: facilitate the appropriate, approved label use of various classes of medications.

Coverage limitations

The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

- Agents used for anorexia (exception of orlistat)
- Cough and cold preparations
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Drugs for the treatment of erectile dysfunction
- DESI drugs or drugs that may have been determined to be identical, similar or related
- Investigational or experimental drugs
- Non-legend or over-the-counter drugs/items (exceptions indicated on PDL)
- Agents prescribed for any indication that is not medically accepted

PDL updates

Humana Healthy Horizons in Louisiana may add or remove drugs on the drug list, as well as UM requirements for covered drugs. During the year as directed by the LDH.

Examples include:

- Elect to require or not require prior authorization
- Elect to change the quantity limits
- Add or change step therapy restrictions
- The Food and Drug Administration (FDA) provides new guidance or clinical guidelines about a drug
- A generic drug is added that is new to the market

We will notify you of negative changes to the PDL at least 30 days prior to implementation. Please review the current formulary prior to writing a prescription to determine if drug will be covered. The PDLs are updated regularly; to view the current PDL and pharmacy coverage policies, go to ldh.la.gov/index.cfm/page/1328.

Medications administered in the provider setting

Humana Healthy Horizons in Louisiana covers medications administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center. Prior authorization requirements exist for many injectables. Humana Healthy Horizons in Louisiana providers can:

- Obtain forms at Humana.com/medPA
- Submit request by fax to **888-447-3430**
- View preauthorization and notification lists at Humana.com/PAL

Immunizations

Humana Healthy Horizons in Louisiana covers Advisory Committee on Immunization Practices (ACIP) vaccines.

- For enrollees age 18 and younger, vaccinations are provided free of charge through the Louisiana Immunization Program/Vaccines for Children (VFC) program.
- For enrollees age 19 and older, vaccines and vaccine administration are covered without restriction or prior authorization

For vaccination administration, enrollees seven years of age and older may obtain influenza and other appropriate vaccines without prescription at network pharmacies in which licensed Pharmacists, Pharmacy Interns & Pharmacy Technicians (under the supervision of a pharmacist) are given.

Coverage determinations and exceptions

You may request coverage determinations, such as medication prior authorization, step therapy, quantity limits and formulary exceptions,

- <Insert information from SBPM>

The coverage determination decision will be reviewed based upon medical necessity and our decision communicated within 24 hours after the request is received from the prescriber.

Copay

Medicines on the PDL will have a copayment based upon the medication cost and a member's monthly income.

Monthly income	Copay
When 5% of family's monthly income is spent on copays	$0
Monthly income	**Copay**
$10 or less	$0.50
$10.01-$25	$1
$25.01-$50	$2
$50.01 or more	$3

However, there are no copays for the following members and services:
- Members 20 years of age and younger
- Federally recognized Native Americans
- Pregnant women
- Family planning
- Emergency services

Medication Therapy Management (MTM) Program

The Medication Therapy Management (MTM) Program enhances a member's medication therapy and minimizes adverse drug reactions through a variety of resources, including telephone and pharmacy-based consultation services.

Humana works with a contracted vendor and community pharmacies to provide eligible Medicaid members with a series of face-to-face MTM consultations at local pharmacies to review members' medcations (includes herbals and over-the counter medications). There is no cost to members. MTM services are designed to:
- Improve safe use of medications
- Improve coordination with doctors and other caregivers
- Increase member knowledge of medications and how to use them correctly

Member education through the MTM Program helps to prevent, or address medication-related problems, improves member medication compliance and decreases costs.

Pharmacy lock-in program

The lock-in program is designed for individuals enrolled in Medicaid in Louisiana who need help managing their use of prescription medications and physician benefits. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the member. Humana members who meet the program criteria will be restricted to:
- One pharmacy and/or specialty pharmacy if needed.
- One primary care provider
- Up to three specialists, if needed

The lock-in program is required by the 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 lock-in program. PCPs and specialists may refer members for evaluation to participate in the lock-in program by calling **<888-285-1113>**.

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's information and the member's right to appeal the plan's decision.

Members are initially locked-in for a total of <12 months>, during which the member can only request a change from their designated lock-in provider one time.

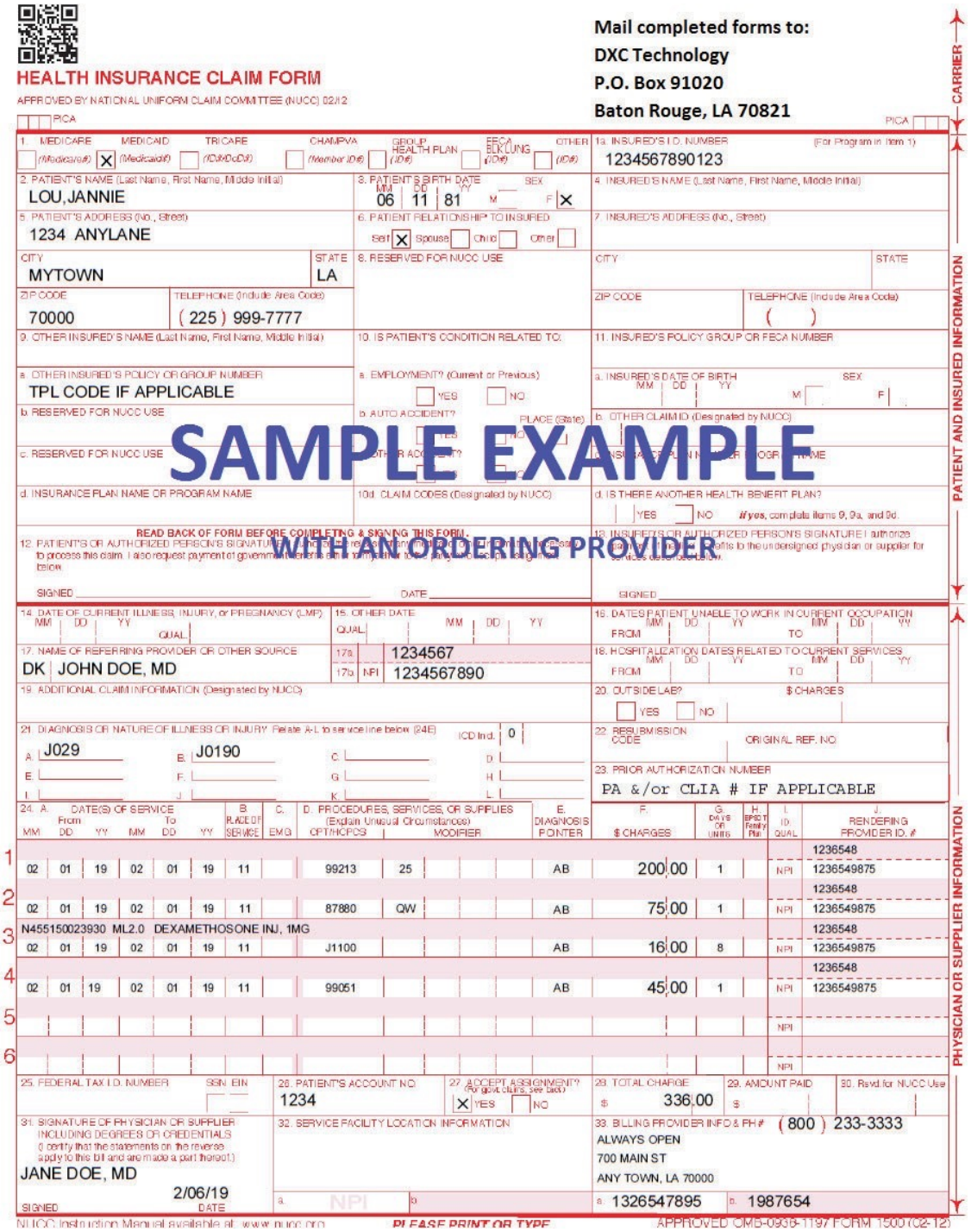
Following the member's <12-month >enrollment, a utilization review is conducted to determine the member's continued need for the program. Once the restriction has been lifted, the member is placed on a six month follow-up for review of prescription history to determine if the lock-in should be reinstated for an additional period of 24 months.

Excluded from enrollment in the lock-in program are:
- Sickle cell and oncology patients
- Recipients residing in institutionalized settings
- Recipients enrolled with Medicare.

Exception: This limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department.

Appendix
LDH clean claim samples

SAMPLE OF PROFESSIONAL CLAIM FORM – REVISED 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

PICA

1. MEDICARE (Medicare#) X | 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 MM DD YY: 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.

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.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

SAMPLE EXAMPLE

WITH AN ORDERING PROVIDER

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

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

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			1236548 NPI 1236549875
2	02 01 19	02 01 19	11		87880	QW		AB	75.00	1			1236548 NPI 1236549875
3	N455150023930 ML2.0 DEXAMETHOSONE INJ, 1MG 02 01 19	02 01 19	11		J1100			AB	16.00	8			1236548 NPI 1236549875
4	02 01 19	02 01 19	11		99051			AB	45.00	1			1236548 NPI 1236549875
5													NPI
6													NPI

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

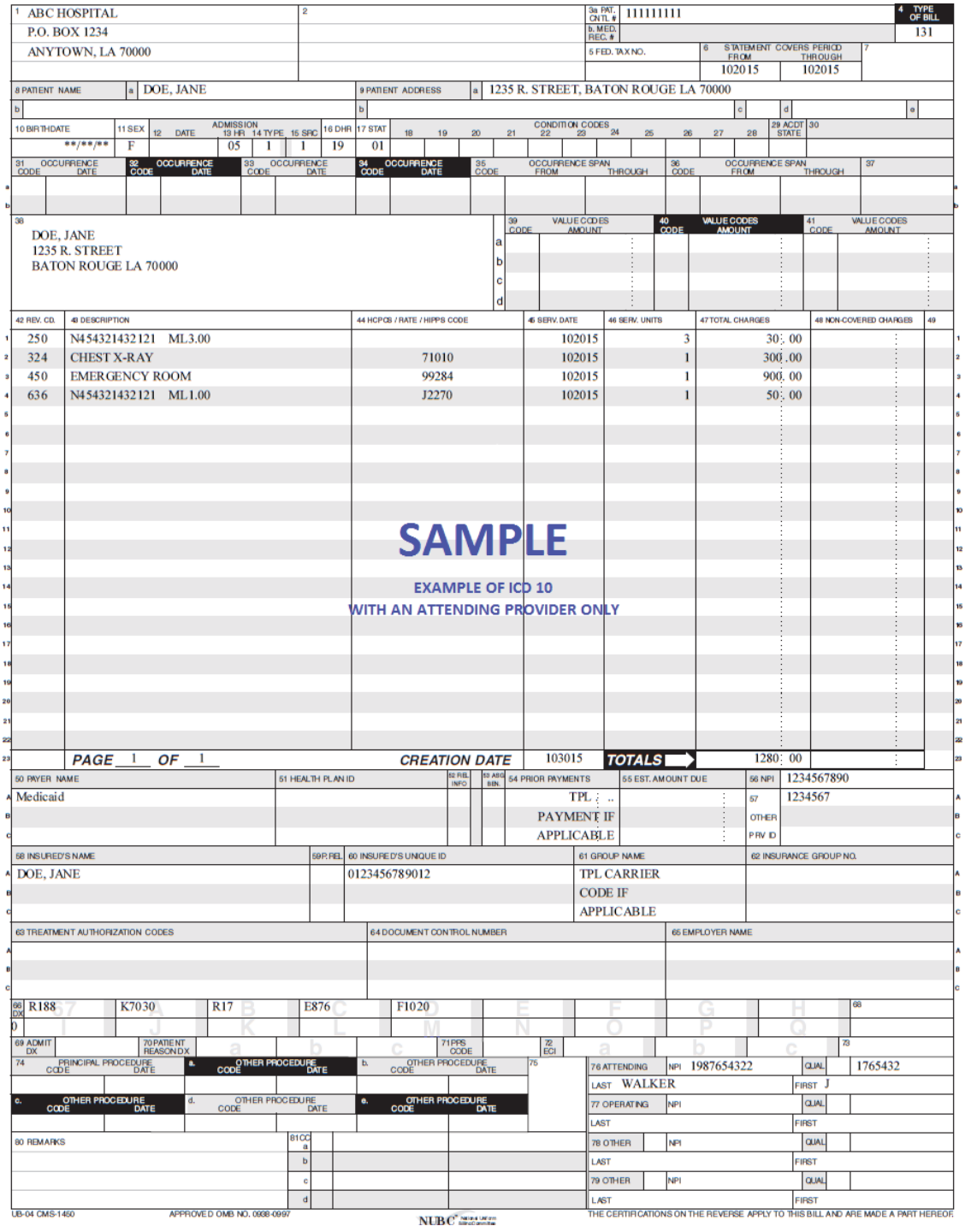
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

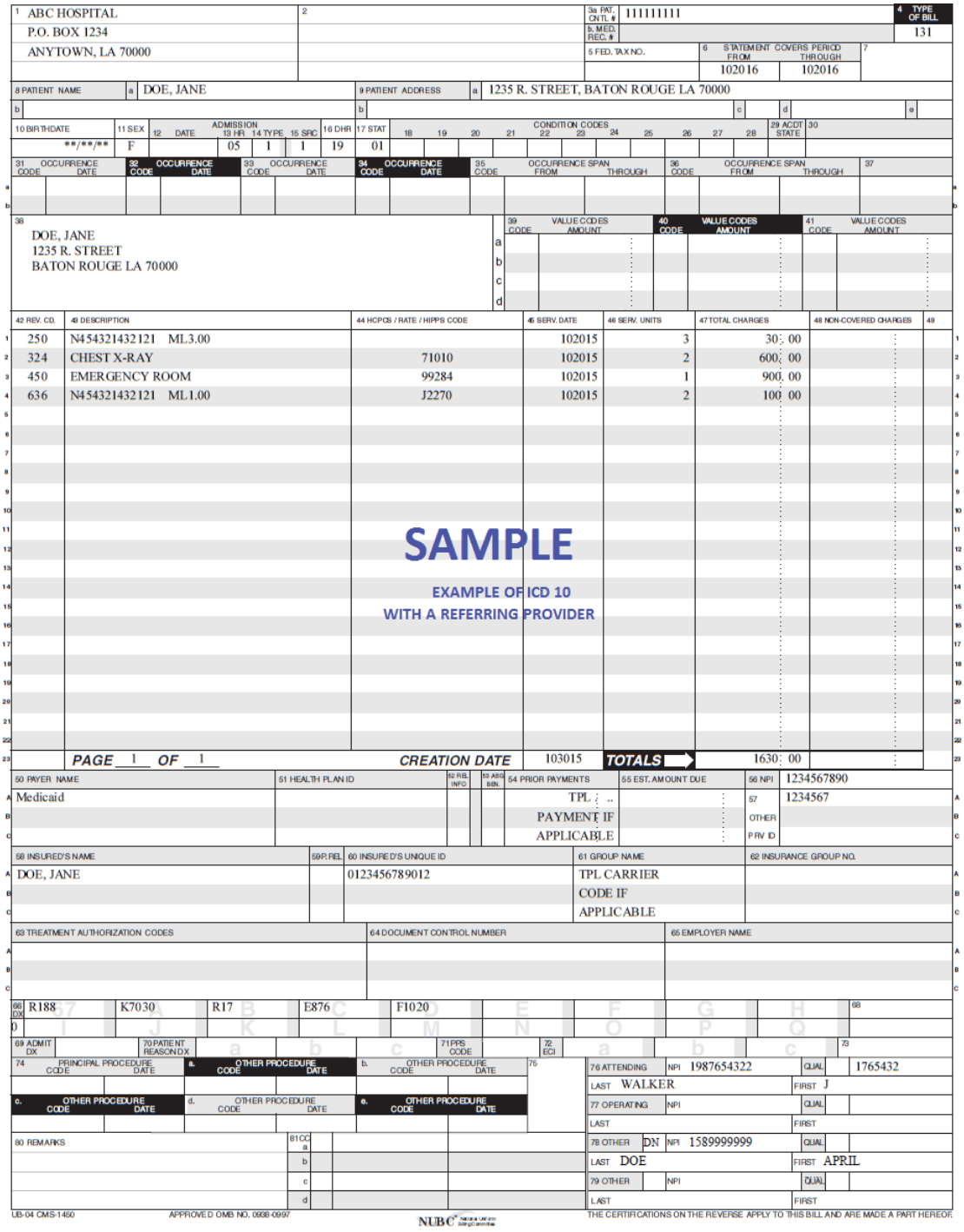
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 10/1/15)



1 ABC HOSPITAL
P.O. BOX 1234
ANYTOWN, LA 70000

3a PAT. CNTL # 111111111
4 TYPE OF BILL 131
6 STATEMENT COVERS PERIOD FROM 102016 THROUGH 102016

8 PATIENT NAME: DOE, JANE
9 PATIENT ADDRESS: 1235 R. STREET, BATON ROUGE LA 70000

10 BIRTHDATE **/**/**
11 SEX F
12 ADMISSION DATE 05
13 HR 1
14 TYPE 1
15 SRC 1
16 DHR 19
17 STAT 01

38 DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
250	N454321432121 ML3.00		102015	3	30. 00	
324	CHEST X-RAY	71010	102015	2	600. 00	
450	EMERGENCY ROOM	99284	102015	1	900. 00	
636	N454321432121 ML1.00	J2270	102015	2	100 00	
	PAGE 1 OF 1	CREATION DATE	103015	TOTALS	1630. 00	

SAMPLE
EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

50 PAYER NAME: Medicaid
56 NPI 1234567890
57 OTHER PRV ID 1234567
54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE

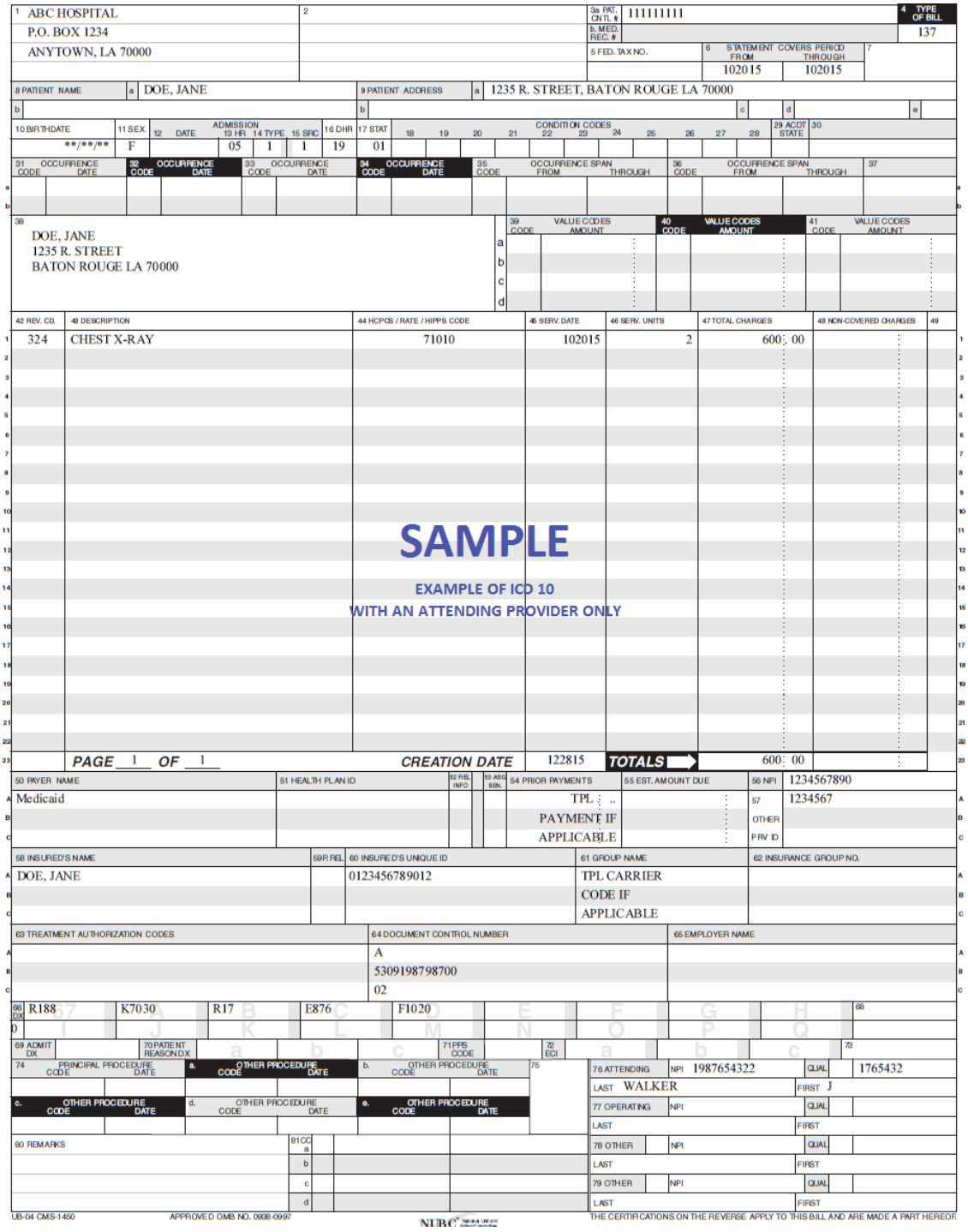
58 INSURED'S NAME: DOE, JANE
60 INSURED'S UNIQUE ID: 0123456789012
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE

66 DX 0: R188 | K7030 | R17 | E876 | F1020

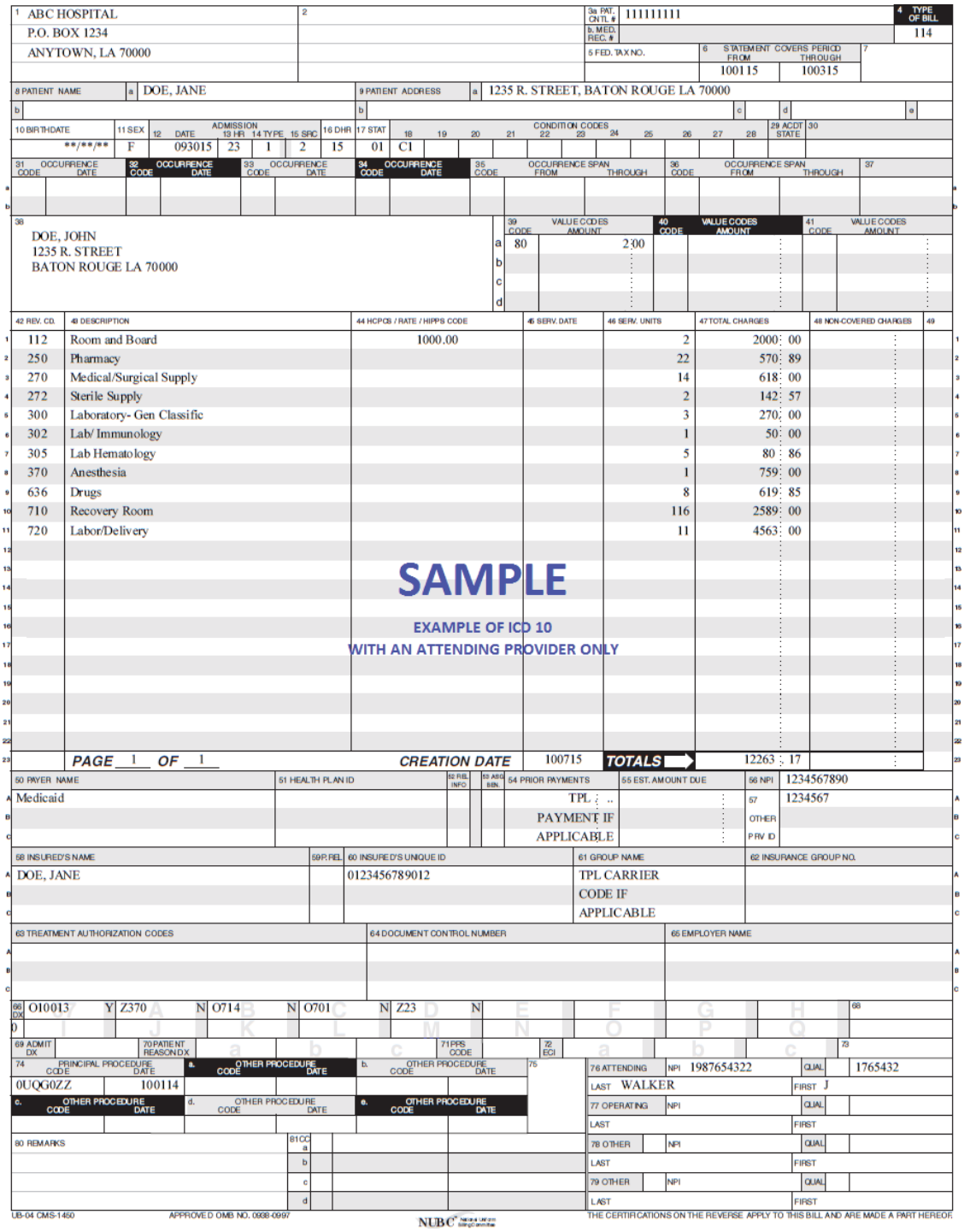
76 ATTENDING NPI 1987654322 QUAL 1765432
LAST WALKER FIRST J
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER DN NPI 1589999999 QUAL
LAST DOE FIRST APRIL
79 OTHER NPI QUAL
LAST FIRST

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 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 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 114
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 100315

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

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	2.00				

	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		2	2000 00		
2	250	Pharmacy			22	570 89		
3	270	Medical/Surgical Supply			14	618 00		
4	272	Sterile Supply			2	142 57		
5	300	Laboratory- Gen Classific			3	270 00		
6	302	Lab/ Immunology			1	50 00		
7	305	Lab Hematology			5	80 86		
8	370	Anesthesia			1	759 00		
9	636	Drugs			8	619 85		
10	710	Recovery Room			116	2589 00		
11	720	Labor/Delivery			11	4563 00		
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE	100715	TOTALS	12263 17		

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		
B		
C		

66 DX																	66
	O10013	Y	Z370	N	O714	N	O701	N	Z23	N							
0	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			

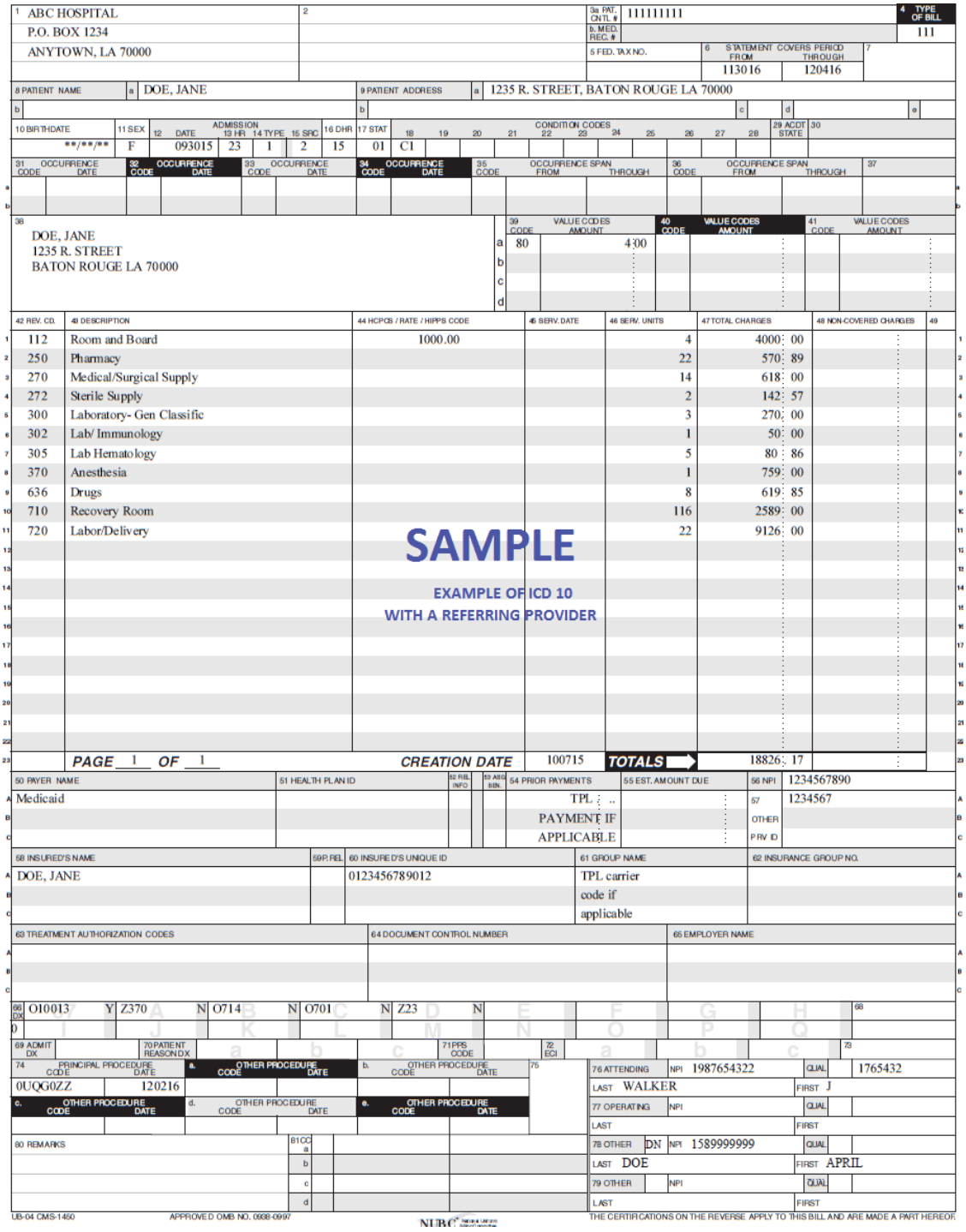
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE

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 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 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
7

8 PATIENT NAME a DOE, JANE
9 PATIENT ADDRESS 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
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
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			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			22	9126.00		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	100715	TOTALS	18826.17		23

SAMPLE

EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

	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	1234567
B					PAYMENT IF		OTHER	
C					APPLICABLE		PRV ID	

	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: O10013 Y | Z370 N | O714 N | O701 N | Z23 N | 66
0

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
0UQG0ZZ	120216					

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

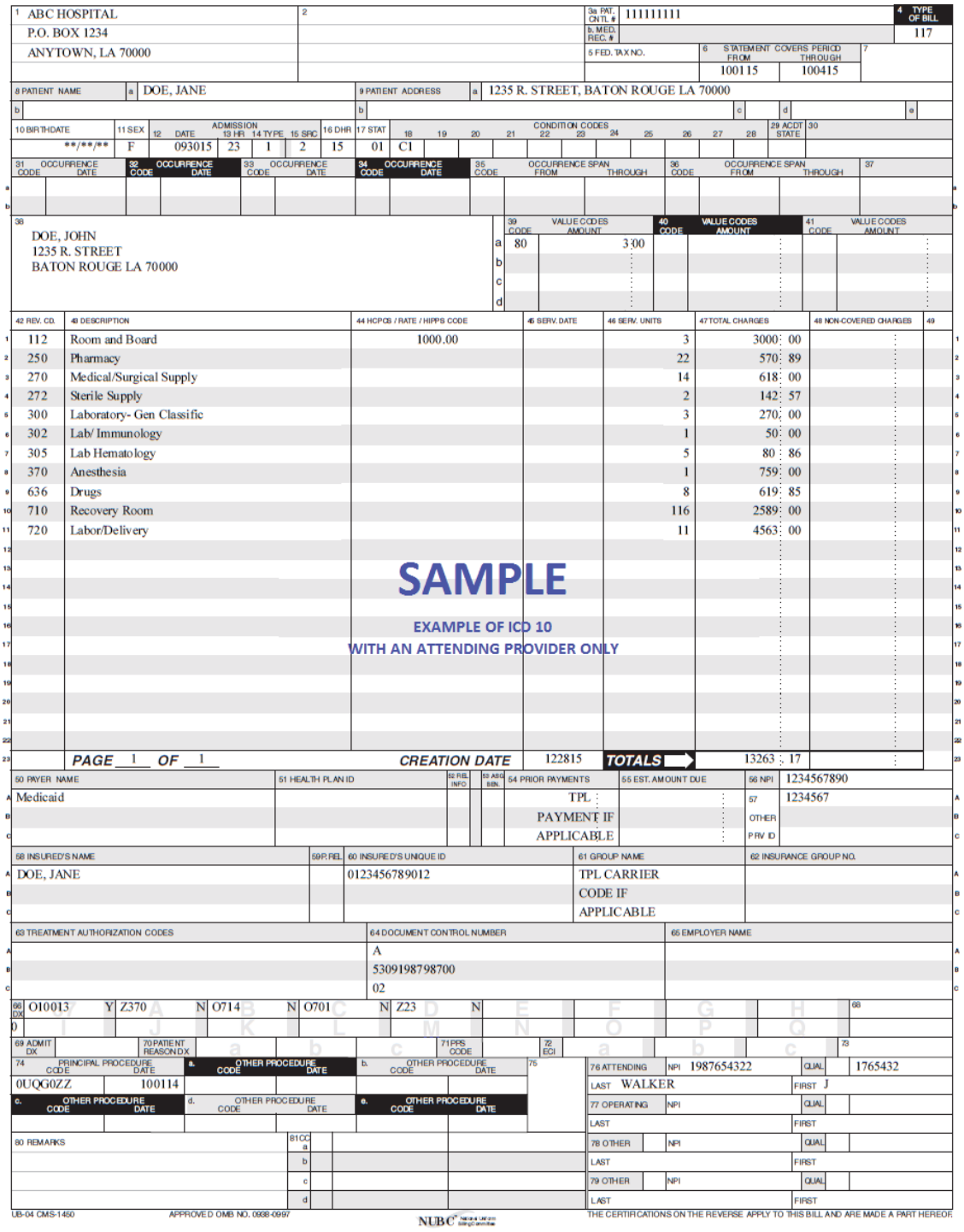
80 REMARKS

81 CC	
a	
b	
c	
d	

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

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 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	18	19	20	21	22	23	24	25	26	27	28	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	A	A
B	5309198798700	B
C	02	C

66 DX																					68
0	O10013	Y	Z370	N	O714	N	O701	N	Z23	N											

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

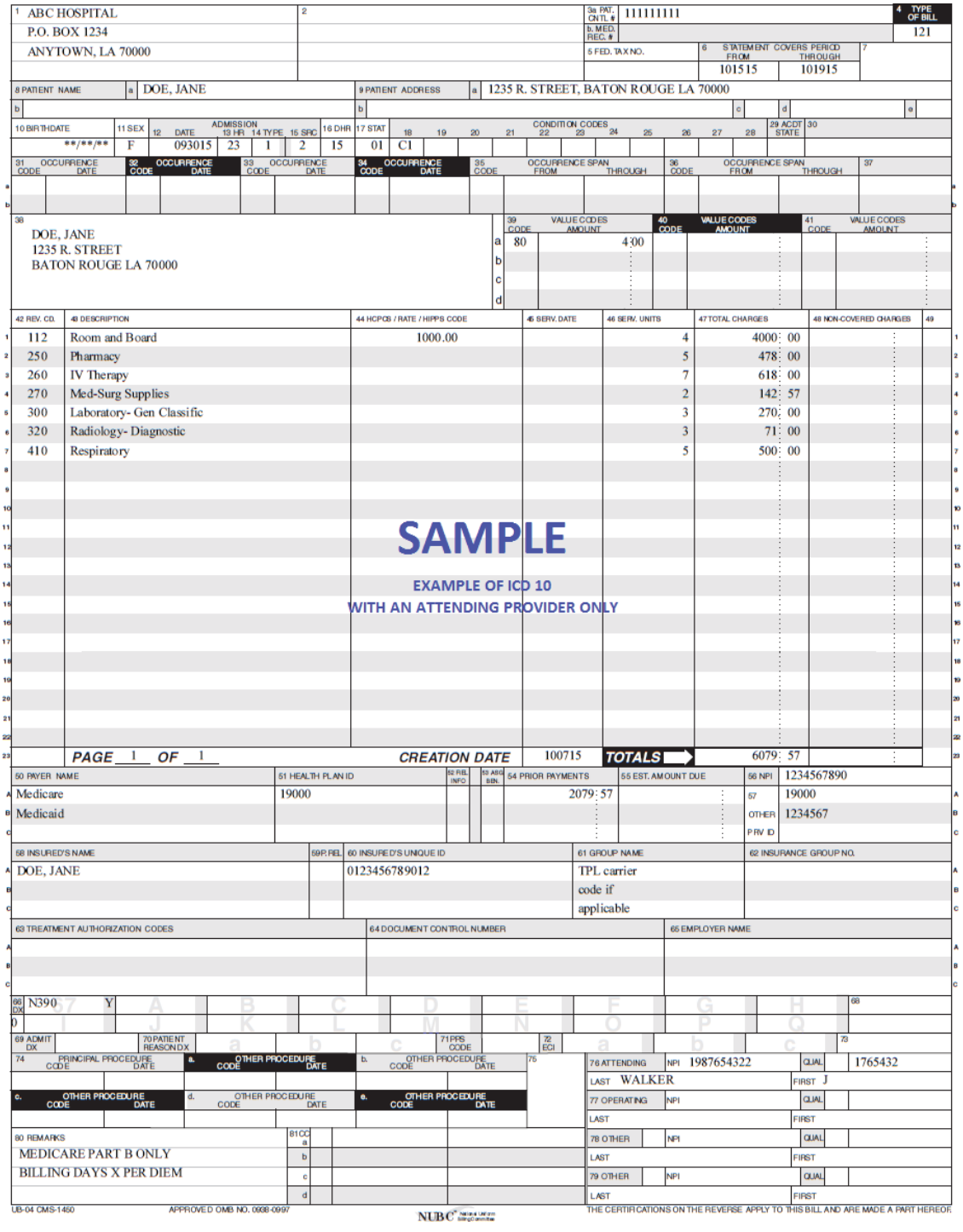
74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
0UQG0ZZ 100114			
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

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	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 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

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 a DOE, JANE
9 PATIENT ADDRESS 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		

31-37 OCCURRENCE CODE / DATE; OCCURRENCE SPAN CODE / FROM / THROUGH

38
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

39-41 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	49
112	Room and Board	1000.00		4	4000: 00		
250	Pharmacy			5	478: 00		
260	IV Therapy			7	618: 00		
270	Med-Surg Supplies			2	142: 57		
300	Laboratory- Gen Classific			3	270: 00		
320	Radiology- Diagnostic			3	71: 00		
410	Respiratory			5	500: 00		
	PAGE 1 OF 1	CREATION DATE	100715	TOTALS	6079: 57		

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

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

66 DX: N390 Y

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 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
MEDICARE PART B ONLY
BILLING DAYS X PER DIEM

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.