Humana

Department: Medicaid Administration	**Policy and Procedure No:** HUM-LA-Medicaid COC Claims Process and Guidelines	
Policy and Procedure Title: Louisiana Medicaid Continuity of Care Claims Process and Guidelines		
Process Cycle: Annually	**Responsible Departments: C**laims Operations	
Approved By: Micky Wheatley & Gregg Schleusner	**Issue Date:** 09/09/2022	**Revised:** 9/14/2022

CONTRACT REFERENCE:

2.8 Continuity of Care

2.8.1.4.9 Provide active assistance to enrollees receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the Contractor. The Contractor shall provide continuation of such services for up to ninety (90) calendar days or until the enrollee is reasonably transferred without interruption of care, whichever is less.

2.12.7.2 Pregnancy

2.12.7.2.1 In the event a new Enrollee is in the first trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of Enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of authorization needed and without regard to whether such services are being provided by a network or non-Network Provider until such time as the Contractor can reasonably transfer the Enrollee to a Network Provider without impeding service delivery that might be harmful to the Enrollee's health.

2.12.7.2.2 In the event a new Enrollee is in her second or third trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of Enrollment, the Contractor shall be respon

sible for providing continued access to the prenatal care provider (whether network or nonnetwork Provider) for sixty (60) Calendar Days postpartum, provi ded theEnrollee remains covered through Contractor, or referral to a safety net provider if the Enrollee's eligibility terminates before the end of the postpartum period.

2.12.7.2.3 In the event a new Enrollee is actively receiving medically necessary MCO Covered Services other than prenatal services at the time of Enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary services, without any form of authorization needed and without regard to whether such s ervices are being provided by network or nonNetwork Providers. The Contra ctor shall provide continuation of such services up to ninety (90) Calendar Days or until the Enrollee may be reasonably transferred to an in Network Provider without disruption, whichever is less. The Contractor may require Prior Authorization for continuation of the services beyond thirty (30) Calendar Days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

2.12.7.2.4 The Contractor shall ensure that the Enrollee is held harmless by the provider for the costs of the above medically necessary MCO Covered Services.

2.12.7.3 Special Health Care Needs

2.12.7.3.1. Where a new Enrollee with SHCN is actively receiving medically necessary MCO Covered Services at the time of Enrollment, the Contractor shall provide continuation/coordination of such services up to ninety (90) Calendar Days or until the Enrollee may be reasonably transferred to a Network Provider without disruption, whichever is less. The Contractor may require Prior Authorization for continuation of the services beyond thirty (30) Calendar Days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider

2.12.7.5 DME, Prosthetics, Orthotics, and Certain Supplies

2.12.7.5.1 In the event an Enrollee who is newly enrolled with the Contractor is actively receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services at the time of Enrollment, whether such services were provided by another MCO or FFS, the Contractor shall be responsible for the costs of continuation of these

services, without any form of authorization and without regard to whether such services are being provided by network or nonnetwork Providers. The Contractor shall provide continuation of such services for up to ninety (90) Calendar Days or until the Enrollee may be reasonably transferred to a Network Provider (within the timeframe specified in this Contract) without disruption, whichever is less.

2.12.7.5.2. The Contractor shall also honor any Prior Authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the Enrollee was enrolled in another MCO or FFS for a period of ninety (90) Calendar Days after the Enrollee's Enrollment.

ACRONYMS & DEFINITIONS:

CAS	Claims Administration System – Humana's claim processing platform
CCR	Clinical Claims Review
COC	Continuity of Care
MCO	Medicaid Contract Organization

PURPOSE:

This Humana Healthy Horizons in Louisiana Plan policy provides guidance and details processes relating to Continuity of Care procedures to meet contractual obligations and to ensure compliance.

POLICY AND PROCEDURE:

Policy:

It is the Plan's policy to ensure timely processing of claims for our new enrollees for their continuity of care. This policy establishes the appropriate claims payment and denials for all claims. It is policy to ensure that all documentations within this document is compliant with the above contractual requirements.

Procedure:

Claims are processed within our Claims Adjudication System (CAS).

For members with Humana who then transfer during a hospitalization, claims will continue to pay until the member is discharged. Members who transfer to Humana from another Medicaid Contract Organization (MCO), claims will not pay for concurrent admission that already began while under the prior MCO coverage and Humana would not be financially responsible until the member is discharged.

The system checks for authorizations when a participating or non-participating provider claim is received. If the system determines an approved authorization is on file, then claim

will be adjudicated for payment. If the CAS system determines there is a denied authorization is on file, the claim will be adjudicated to deny.

In the event the system does not find an approved or denied authorization, the CAS system will compare the date of service to the effective date of the member. If the member is within their COC timeframe of ninety (90) calendar days and there is not an approved/denied authorization on file, the claim will pend to our Clinical Claims Review (CCR) via a specific pend code created for Louisiana Medicaid enrollees, which generates a claims edit of MCDCOC. The following additional rules apply in specific situations:

- For COC for pregnant women, Humana's claims system uses automated system rules to process claims to ensure continued coverage, based on guidelines established by the Humana Market Team. This includes:
  - If the pregnant enrollee is receiving medically necessary services other than or in addition to prenatal care, such services can continue up to ninety (90) calendar days or until the enrollee may be reasonably transferred without disruption, whichever is less. Prior authorization can be required after thirty (30) calendar days but will not be denied solely because a provider is not contracted.
  - If the enrollee is in the first trimester and receiving medically necessary covered prenatal services, such services can continue without prior authorization, from either contracted or non-contracted providers, until the enrollee can be reasonably transferred to a network provider without impeding services at the risk of harming the member's health.
  - If the enrollee is in the second or third trimester and receiving medically necessary covered prenatal services, the enrollee will have continued access to the prenatal care provider (contracted or non-contracted) for sixty (60) calendar days post-partum, provided the enrollee remains covered through Contractor or will have referral to a safety net provider if the enrollee's eligibility terminates before the end of the post-partum period.
  - Enrollees are held harmless by the provider for costs of medically necessary covered services.

- For enrollees with special health care needs, when the enrollee is actively receiving such medically necessary covered services, such services can continue up to ninety (90) calendar days or until the enrollee may be reasonably transferred without disruption, whichever is less. Prior authorization can be required after thirty (30) calendar days but will not be denied solely because a provider is not contracted.

- For COC for DME, prosthetics, orthotics, and certain covered supplies, when the enrollee is actively receiving such medically necessary covered services, such services can continue up to ninety (90) calendar days or until the enrollee may be reasonably transferred without disruption, whichever is less. Humana accepts prior authorizations that were issued before the enrollee transferred to Humana for a period of ninety (90) calendar days.

After the review from Humana's CCR team, the claim will be pended to Claim Operations via a specific pend code created for Louisiana Medicaid enrollees, for the

claim to process based on the nurse's guidance. The claim adjuster will review the note from the CCR team and adjudicate according to their recommendations. For example, the authorization is approved for COC period of 60 days.

ADDITIONAL RESOURCES:

The following documents can be found in Mentor:
MCDCOC
PEND CODE 49V
PEND CODE 51U
Louisiana Continuity of Care
ELIG ERR for Medicaid

VERSION CONTROL:

Version.Review.Approval History				
Department:	**Purpose of Review**	**Reviewed and Approved By:**	**Date:**	**Additional Comments:**
Claims	Moved procedure to new template	Micky Wheatley & Gregg Schleusner	09/07/2022	
Claims	Corrected additional resources	Micky Wheatley & Gregg Schleusner	09/09/2022	
Claims	Updated document with the 8/23/2022 contract version	Micky Wheatley & Gregg Schleusner	9/14/2022	
Regulatory Compliance	Compliance Review	Amy Brandon	9/14/2022	

DISCLAIMER:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by an issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or

information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained by CMU to ensure no modifications have been made.

NON-COMPLIANCE:

Failing to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to non-compliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet of Hi! (Workday & Apps/Associate Support Center).