2026

Provider Manual

Humana Healthy Horizons in Louisiana is a Medicaid Product of Humana Health Benefit Plan of Louisiana, Inc.

Humana
Healthy Horizons®
in Louisiana

980301LA0326 3LAHLQG9EN

Contents

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

In this manual, you can easily find information about:

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

Humana Healthy Horizons 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, visit **Humana.com/HealthyLA** or call us at **1-800-448-3810 (TTY: 711)**.

Thank you for partnering with Humana Healthy Horizons 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 December 2023, more than 1.68 million Louisiana residents were enrolled with an 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, 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' contract to provide services to Louisiana

Medicaid beneficiaries underscores its support of Louisiana's ongoing Triple Aim focus.

Humana Healthy Horizons 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 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 Healthy Horizons cannot be implemented until it is approved by LDH after the public has a chance to comment (during a 45-day public comment period). The act considers policy and procedure to include any guidelines describing:

- Billing
- Medical management and utilization review
- Case management
- Claims processing
- Grievances 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 Healthy Horizons are prohibited from enforcing any policy or procedure that is not adopted in compliance with the public comment period and procedures detailed in Act 319.

Chapter 2: Communicating with Humana Healthy Horizons

By phone (all operating hours in local time):

Provider and Medicaid member services: 1-800-448-3810 (TTY: 711), 7 a.m. – 7 p.m., Monday – Friday

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

24-hour Behavioral Health Crisis Line (24/7/365): 1-855-24CARE5 or 1- 855-242-2735

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

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

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

Prior authorizations for medications on the Preferred Drug List (PDL): 1-800-555-2546

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

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

Availity Essentials™ customer service/tech support: 1-800-282-4548, 7 a.m. – 7 p.m., Monday – Friday

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

Louisiana Medicaid Fraud and Abuse Hotline: 1-800-488-2917

Humana fraud, waste and abuse reporting: 1-800-614-4126

By mail:

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

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

Member grievances and appeals
P.O. Box 14546
Lexington, KY 40512-4546

Fraud, waste and abuse
1100 Employers Blvd.
Green Bay, WI 54344

Provider complaints
Attn: Provider Relations
1 Galleria Blvd., Suite 1000
Metairie, LA 70001-2081

Helpful websites **Humana.com**

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

Providers also may obtain plan information from **Humana.com/providers**. This information includes the following:

- Health and wellness programs
- Clinical practice guidelines (CPGs)
- Provider publications (including handbooks, newsletters and program updates)
- Pharmacy services
- Claim resources
- Quality resources

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

Provider portal

Humana Healthy Horizons partners with Availity Essentials to give providers access to member and claim data for multiple payers all in one place. Availity Essentials offers access to:

- Member eligibility and benefits
- Prior authorizations
- Claim status
- Claim submission
- Appeal and dispute submission
- Remittance advice
- Staff rosters of credentialed and contracted providers of mental health rehabilitation services
- Education and training materials including the Humana Healthy Horizons Louisiana Medicaid provider manual
- Member MCO care plans and health needs assessments To learn more, call **1-800-282-4548** or visit **Availity Essentials**.

Chapter 3: Provider services

Primary care providers (PCPs)

The PCP shall serve as the member's initial and most important point of interaction with the Humana Healthy Horizons 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 PCP 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 members choose or are assigned to a PCP on enrollment in the plan. PCPs help facilitate a "medical home" for members. This means PCPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners. PCPs also are required to know how to screen and refer members for behavioral health conditions.
- For more information, please refer to this chapter, and Chapter 4: Covered services, and the behavioral health services subsection.

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, 7 days a week
- Have hospital admitting privileges or a formal referral agreement with a PCP who has hospital admitting privileges

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

- Availability of a personal healthcare practitioner to assist with coordinating a member's overall care, as appropriate for the member
- Continuity of the member's total healthcare

- Early detection and preventive healthcare services
- Elimination of inappropriate and duplicate services

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

- Treating Humana Healthy Horizons 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, subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available, and communicating with all other levels of medical care to coordinate and follow up the care of individual patients
  - For providers seeking assistance in finding a specialist for their patients, please email **LAMCDSDOH@humana.com**.
- Providing the coordination necessary for referring patients to specialists
- Maintaining a medical record of all services rendered by the PCP and a record of referrals to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care
- Developing 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 CFR Parts 160 and 164 and all state statutes
  - 45 CFR. 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 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 SDOH to determine whether the member needs behavioral health services or linkages to community-based organizations to address SDOH
- Consulting with behavioral health specialists to ensure basic behavioral health services are available in the primary care setting

  - PCPs can contact the Humana Healthy Horizons behavioral health medical director by sending a request for consultation via encrypted email to **LAMCDCaseManagement@humana.com** with the subject line "BH Consult Request." The request should include member name, Medicaid ID, reason for consult and PCP contact information.
  - PCPs can utilize the Provider to Provider Consultation Line (PPCL) for questions related to pediatric or perinatal mental health.
    1. First, register for the PPCL by completing the **Registration Form**.
    2. Then call **1-833-721-2881** for a consult. A mental health consultant will respond to questions about behavioral health and local resources. The consultant can connect you to one of the on-call psychiatrists to assist with diagnostic clarification and medication management questions.
- Maintaining continuity of the member's healthcare
- Identifying the member's health needs and taking appropriate action
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week
- Making referrals for specialty care and other medically necessary services, both in and out of network, if such services are not available within the Humana Healthy Horizons network
- Following all referral and prior authorization policies and procedures as outlined in this manual
- Complying with the quality standards of Humana Healthy Horizons and 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-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 LDH's specifications
- Obtaining patient records from facilities visited by Humana Healthy Horizons patients for emergency or urgent care, if notified of the visit
- Ensuring demographic and practice information is up to date for directory and member use
- Referring members to behavioral healthcare providers and arranging appointments, when clinically appropriate
- Assisting with coordination of the member's overall care, as appropriate
- Serving as the ongoing source of primary and preventive care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for persons younger than 21
- Recommending referrals to specialists, as required
- Participating in the development of care management and treatment plans and notifying Humana Healthy Horizons of members who may benefit from care management

- Maintaining formalized relationships with other PCPs to refer their members for after-hours care, during certain days, for certain services or other reasons to extend their practices
- Understanding and agreeing that provider performance data can be used by Humana Healthy Horizons
- Understanding that all network hospitals are required to comply with the data submission requirements of Louisiana Revised Statues 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 (HIEs) when 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, 7 days a week and shall not discriminate against members. Members should be triaged and provided appointments for care within the time frames below.

Medical care:

Provider/facility type	Standard
Emergencies and urgent care	
Emergency care	24 hours, 7 days/week within 1 hour of request
Urgent nonemergency care	24 hours, 7 days/week within 24 hours of request
Primary care	
Nonurgent sick	Within 72 hours
Nonurgent 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
Specialty care	
Specialist appointment	1 month
Waiting room time	
Scheduled appointments	< 45 minutes
Accepting new patients	
Provider office open to new patients	Provider listed in directory and/or registry file as open

Behavioral health care:

Provider/facility type	Standard
Specialized behavioral health providers	
Emergency care	24 hours, 7 days/week within 1 hour of request
Nonurgent routine	14 days
Urgent nonemergency care	48 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 Addiction Medicine (ASAM) levels 3.3, 3.5 and 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 also are expected to:

- Request healthcare insurance information and verify member eligibility before rendering service
  - You can verify member eligibility and obtain information for other healthcare insurance coverage we have on file by accessing the provider portal at **Availity Essentials**.
- 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
- Treat members with respect
  - Humana Healthy Horizons members should not be treated differently than patients with other healthcare insurance.

Women's preventive health

Humana Healthy Horizons provides coverage for 1 well-woman gynecological examination per year, with no preauthorization or referral required, for women 21 years and older, when performed by the member's PCP or in-network gynecologist. This is in addition to 1 preventive medicine visit for adults age 21 and older. This is to allow women access to the gynecological components of annual preventive screening visits and is not to be considered duplicative service. The well-women visit includes an examination, lab work, sexually transmitted infection (STI) screening, a mammogram

(members age 40 and older), a Pap test (annually for members age 21 and over) and contraceptive methods and counseling, as appropriate.

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

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

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

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

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

Family planning

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

The services include:

- A comprehensive medical history and physical exam at least once per year. This visit includes anticipatory guidance and education related to the member's reproductive health/needs
- Contraceptive counseling (including natural family planning), education, follow-up visits and referrals
- Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health
- Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the U.S. Food and Drug Administration (FDA)

- Drugs for the treatment of lower genital tract and genital skin infections/disorders and urinary tract infections when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/ encounter for the treatment/drugs also may be covered
- Male and female sterilization procedures provided in accordance with 42 CFR. Part 441, Subpart F Treatment of major complications from certain family planning procedures such as treatment of a perforated uterus due to intrauterine device insertion, treatment of severe menstrual bleeding caused by a medroxyprogesterone acetate injection requiring dilation and curettage, and treatment of surgical or anesthesia-related complications during a sterilization procedure.
- Transportation services to and from family planning appointments provided all other criteria for nonemergency 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 STIs
  - Prior authorization 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.

Practitioners are strongly encouraged to provide their language, race and ethnicity for Humana Healthy Horizons to reference when members call requesting practitioners with the same race, ethnicity and language as themselves.

Education

Humana Healthy Horizons 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 comply with all training requirements identified as compliance-based by the contract and Humana Healthy Horizons. This includes agreement and assurance that all affiliated participating providers and staff members comply with required training.

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 and training
- Cultural competency
- Health, safety and welfare (abuse, neglect and exploitation)

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

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
- 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 Healthy Horizons' Medicaid provider orientation.

Providers and their office staff can access these online training modules 24 hours a day, 7 days a week, at **Humana.com/ProviderCompliance**.

For additional provider training, visit **Provider portal webinars and resources**.

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' request.

Marketing materials

Marketing materials will not be distributed through Humana Healthy Horizons' provider network.

Distribution of branded health education supplies will be limited to Humana Healthy Horizons 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 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 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 they are 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 than the MCO name and/or logo or with the statement of facility acceptance.

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

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

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

Key contract provisions

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

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

In compliance with the Affordable Care Act and the 21st Century Cures Act, federal law requires that states screen and enroll providers; therefore, all providers who order, prescribe, refer, provide services or seek prior authorization for services for Humana Healthy Horizons members must enroll in Medicaid through the **provider enrollment portal**. If enrollment cannot be validated or is incomplete, providers risk not being paid. Providers who are unsure of their enrollment status or want to check their status may use the **provider portal enrollment lookup tool**. Results will show the provider's status as either enrollment complete, action required, application not submitted or currently in process. Providers not shown in the results are not required to enroll at this time. Invitation letters for those providers will be sent at a later date. The lookup tool is updated daily.

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

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

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

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

- Processing to either pay or deny a clean claim within 30 calendar days of receipt of the claim
- Processing all claims, including pended claims, within 60 calendar days of receipt of the claim
- Paying or denying all (100%) pended claims within 60 calendar days of the date of receipt
- Providing you with an appeals procedure for timely resolution of requests to reverse a Humana Healthy Horizons determination regarding claim payment
  - Our appeal process is outlined in the "Appeals and grievances" 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 fee schedule for a covered service, Humana Healthy Horizons will not pay any additional amount.

- If the member's primary insurance pays less than the Humana Healthy Horizons fee schedule for a covered service, Humana Healthy Horizons 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

Specialized Behavioral Health providers are required to complete and submit reports of an adverse incident to Humana Healthy Horizons that involve members of the Specialized Behavioral Health population within 1 business day of discovery of the incident on the state mandated form. This state mandated form will have instructions for how to submit the form to Humana Healthy Horizons.

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

- DCFS
- Adult Protective Services (APS) for vulnerable individuals age 18 to 59
- Governor's Office of Elderly Affairs Elderly Protective Services (EPS) for vulnerable individuals age 59 and older; and
- LDH Health Standards Section (HSS) for people who reside in a public or private intermediate care facility (ICF) or ICF/nursing facilities, persons with developmental disabilities (ICF/DD), and DCFS or APS cases in which the alleged perpetrator is an employee of an agency licensed by HSS

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

The following are types of adverse incidents:

- Abuse (child/youth): 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 tolerating by the parent or 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 Louisiana law (Louisiana Children's Code Article 603(2))
- Abuse (adult): The infliction of physical or mental injury, or actions that may reasonably be expected to inflict physical injury, on an adult by other parties, including, but not limited to, such

means as sexual abuse, abandonment, isolation, exploitation or extortion of funds or other things of value (Louisiana Revised Statutes 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 an older adult or an adult with a disability, or the use of power of attorney or guardianship of an older adult or an adult with a disability, for one's own profit or advantage (Louisiana Revised Statutes 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 (Louisiana Revised Statutes 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 illegal prenatal drug exposure caused by the parent, resulting in the newborn being affected by the drug exposure and withdrawal symptoms (Louisiana Children's Code Article 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 the adult's well-being
  - No adult who is provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused (Louisiana Revised Statutes 15:1503.10).

Credentialing and recredentialing

Practitioners within the scope of credentialing for Louisiana Medicaid include:

- Medical and osteopathic doctors
- Oral surgeons
- Chiropractors
- Podiatrists
- Dentists
- Optometrists
- Other licensed or certified practitioners, including provider extenders who act as a PCP or those who appear in the provider directory

- Pharmacists who practice within a medical office setting

Behavioral health providers, including those who are:

- Fully licensed mental health professionals, meaning licensed mental health professionals (LMHPs) who are licensed in the state of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable laws and their professional license
  - LMHPs include the following specialists who are licensed to practice independently:
    - Medical psychologists
    - Licensed psychologists
    - Licensed clinical social workers (LCSWs)
    - Licensed professional counselors (LPCs)
  - Licensed marriage and family therapists (LMFTs)
  - Licensed addiction counselors (LACs)
  - Advanced practice registered nurses (APRN) who meet behavioral health specialist qualifications
- As permitted by service and provider qualifications, certain provisionally licensed providers, including:
  - Provisionally licensed professional counselors (PLPCs)
  - Provisionally licensed marriage and family therapists (PLMFTs)
- As permitted by service and provider qualifications, certain providers with a master's level of education, including:
  - Licensed master social workers (LMSWs)
  - Certified social workers (CSWs)
- As permitted by service and provider qualifications, certain behavioral health intern providers, including:
  - Psychology interns from an internship program approved by the American Psychological Association (APA)
- As permitted by service and provider qualifications, certain individuals employed by a LDH licensed behavioral health service provider (BHSP) who have a bachelor's level of education from an accredited university or college in at least one of the following fields:
  - Counseling
  - Social work
  - Psychology
  - Sociology
  - Rehabilitation services
  - Special education
  - Early childhood education

  - Secondary education
  - Family and consumer sciences
  - Criminal justice
  - Human growth and development
- As permitted by service and provider qualifications, certain individuals employed by a licensed BHSP who have a bachelor's level of education from an accredited university or college with a minor in at least one of the following fields:
  - Counseling
  - Social work
  - Sociology
  - Psychology
- As permitted by service and provider qualifications, certain unlicensed individuals employed by a licensed BHSP who:
  - Meet established age requirements
  - Have completed the required training as determined by the service(s) offered
  - Meet all other applicable requirements defined in the **Louisiana Medicaid Behavioral Health Services Provider Manual**

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

- Staff roster
- Profiling form(s)
- Attestation for services offered

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

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

Joining the Humana Healthy Horizons provider network

Providers interested in contracting with Humana Healthy Horizons 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:

- Provider, practice and/or facility name
- Service address with phone, fax and email information
- Mailing address, if different from the service location
- Taxpayer Identification Number (TIN)
- Practicing specialty
- Louisiana Medicaid provider number, including the registered provider and specialty type codes if applicable
- National Provider Identifier (NPI)
- Type of contract 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 are 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 Healthcare (CAQH®) number. Please ensure your CAQH® application and supporting documents are current and that you've granted Humana Healthy Horizons access to your application.
  - Facilities will be asked to complete Humana Healthy Horizons' Organizational Provider Assessment Form and include supporting documentation applicable to your provider type.
- Proof of current insurance coverage
  - Professional liability insurance coverage or coverage through the Louisiana Patient Compensation Fund
- Disclosure of Ownership

Humana Healthy Horizons will acknowledge receipt of your application within 5 calendar days. If your application is incomplete, including missing, invalid or expired information or documentation, we will notify you in writing within 30 calendar days. Complete credentialing applications are processed within 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 participates with CAQH. You can confirm we have access to your credentialing application by completing the following steps:

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

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

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

Failure to submit a complete application may result in a delay in our ability to begin or complete 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 5-year work history
- Current DEA certificate and/or state narcotics registration, as applicable
- Education, training and experience current and appropriate to the scope of practice requested
- Successful completion of all training programs pertinent to one's practice

  - For providers, 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, in good standing with federal and state agencies, including but not limited to:
  - Medicaid agencies
  - The Medicare program
  - Health and Human Services Office of Inspector General (HHS-OIG)
  - General Services Administration (GSA, formerly Excluded Parties List System/EPLS)
- Active hospital privileges, as applicable
- 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 provider group ownership

Organizational credentialing and recredentialing—physical health

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

- Hospitals
- Psychiatric hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Hospice providers

- Dialysis centers
- Physical and occupational therapy and speech-language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals including outpatient locations
- Diabetes education
- Portable X-ray suppliers
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- School-based health clinics
- Local parish health clinics
- Indian healthcare providers

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

- Confirmation of the organization's good standing with:
  - Medicaid agencies
  - The Medicare program
  - HHS-OIG
  - GSA, formerly EPLS
- Healthcare providers screened by and enrolled with LDH to be considered for participation
- Active and valid Louisiana Medicaid ID
- Organization reviewed and approved by CMS or an accrediting body
- Copy of facility's state license, as applicable
- NPPES
- Current CLIA certificates, as applicable
- Completion of a signed and dated application
- Completed disclosure of ownership form

Organizational credentialing and recredentialing—behavioral health

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

- Therapeutic group homes (TGHs)
- Therapeutic foster care
- PRTFs
- FQHCs
- RHCs

- Outpatient therapy facilities by LMPH groups
- Mental health rehabilitation agencies(MHR)
- Mental health clinics (MHC) – reserved for local government agencies (LGE)
- Community mental health centers (CMHCs)
- School-based health centers
- Substance use residential treatment facilities
- Substance use and alcohol abuse centers (outpatient)
- Opioid treatment programs (OTP)
- Free-standing psychiatric hospitals
- Distinct part psychiatric units
- Center based respite
- Crisis receiving centers
- Personal care services (PCS) – behavioral health
- Behavioral health services provider agencies offer the following evidence-based practice services:
  - Assertive Community Treatment (ACT)
  - Functional Family Therapy (FFT)
  - Functional Family Therapy—Child Welfare (FFT-CW)
  - Homebuilders®
  - Multisystemic therapy (MST)

Elements assessed for organizational providers providing behavioral health services:

- Confirmation of the organization's good standing with:
  - Medicaid agencies
  - The Medicare program
  - HHS-OIG
  - GSA, formerly EPLS
- Healthcare providers screened by and enrolled with LDH to be considered for participation as applicable
- Active and valid Louisiana Medicaid ID as applicable
- Organization reviewed and approved by an accrediting body approved by LDH, as applicable
- LDH approved accrediting bodies are:
  - The Joint Commission (TJC)
  - The Commission on Accreditation of Rehabilitation Facilities (CARF)
  - The Council on Accreditation (COA)

- Copy of facility's state license, as applicable
- NPI, as verifiable via the NPPES
- Current CLIA certificates, as applicable
- Completion of a signed and dated application
- Completed disclosure of ownership form

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

- Staff roster
- Profiling form(s)
- Attestation for services offered

Provider recredentialing

Network providers, including practitioners and organizational providers, are recredentialed at least once every 3 years. In accordance with Louisiana Revised Statutes 46:460.72(B), providers are sent at least 3 written notices and given at least 6 months' notice of their recredentialing due date. As part of the recredentialing process, Humana Healthy Horizons also examines performance information regarding complaints and safety and quality issues collected through the quality improvement program. Additionally, information regarding adverse actions is collected from the National Practitioner Data Bank (NPDB), Medicare and Medicaid sanctions, the CMS Preclusion List, the HHS-OIG and GSA (formerly EPLS), and limitations on licensure.

Exemption from MCO credentialing and recredentialing

In accordance with Louisiana Revised Statutes 46:460.61, Humana Healthy Horizons will consider providers who maintain hospital privileges or are members of the medical staff of a hospital, FQHC or RHC, as having satisfied, and be otherwise exempt from having to satisfy, any credentialing requirements for the Humana Healthy Horizons provider network. Humana Healthy Horizons will track providers who were credentialed by a hospital, FQHC or RHC, including the expiration and/or termination of privileges and/or employment. 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 Healthy Horizons will follow the standard process for credentialing a new provider.

Provider rights

- Providers have the right to review, upon request, information submitted to the Humana Healthy Horizons credentialing department in support of the provider's credentialing application. Humana Healthy Horizons 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.

- Providers have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the credentialing department prior to presentation to the credentialing committee. If information obtained during the credentialing or recredentialing process varies substantially from the application, the provider is notified and given the opportunity to correct information prior to presentation to the credentialing committee.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the credentialing department.

Provider responsibilities

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

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

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

Delegation of credentialing/recredentialing

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

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

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

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

Humana Healthy Horizons will not delegate credentialing of specialized behavioral health providers except as allowed by La. R.S. 46:460.61 or approved by LDH in writing in advance.

Reconsideration of credentialing and recredentialing decisions

Humana Healthy Horizons' 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 they are affected by an adverse determination.

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

Mail it to:
Humana
Attn: Shoba Srikantan, M.D.
Humana 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 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, in which the provider has the right to request a fair hearing. Practitioners denied renewal of their credentials may reapply for network participation once they meet the minimum of the health plan's credentialing criteria.

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

Excluded providers

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

Provider disputes

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

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

Adverse actions

Humana Healthy Horizons complies with the federal Health Care Quality Improvement Act of 1986 and has an active peer review committee. Humana Healthy Horizons reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a network provider, who, in the opinion of the peer review committee, exhibits competence or professional conduct that adversely affects, or could adversely affect, a patient's health or welfare. Participating providers who are subject to an adverse action that limits, reduces, restricts, suspends, terminates, denies or fails to renew a provider's status for more than 30 days are offered an opportunity to require a hearing before a separate hearing panel or officer. Such adverse actions are reported to the NPDB.

Delegated services, policies and procedures

Scope

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

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

Overview

Humana Healthy Horizons 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 healthcare providers and facilities

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 market office provider representative for detailed information on delegation or call Provider Relations at **1-800-448-3810 (TTY: 711)**.

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

Oversight

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

Oversight is the formal process through which Humana Healthy Horizons 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 policies and procedures, as well as the delegate's underlying contractual requirements pertaining to the provision of healthcare services
- Financial soundness (if delegated for claims adjudication and payment)

The delegation process begins with Humana Healthy Horizons performing a predelegation audit prior to any function being delegated to a prospective entity. After approval and an executed delegation agreement, Humana Healthy Horizons 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 following, as applicable:

- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Subdelegation agreement(s)
- Audit(s) of subdelegate'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 continues to monitor all delegated entities through the collection of periodic reporting outlined within the delegation agreement. Humana Healthy Horizons provides the templates and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons 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 requirements, federal and state laws, rules and regulations, or accreditation organization standards may result in a written corrective action plan (CAP). The

delegate must provide a written response describing how the delegate will meet the requirements found to be noncompliant, including the expected remediation date of compliance.

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

Humana, legal, regulatory and accreditation requirements

The delegate must comply with the following requirements:

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

Subdelegation

The delegate must have Humana Healthy Horizons' prior written approval for any subdelegation by the delegate of any functions and/or activities and notify Humana Healthy Horizons of any changes to functions being delegated. The delegate must provide Humana Healthy Horizons with documentation of the pre-delegation audit the delegate performed of the subcontractor's compliance with the functions and/or activities to be delegated.

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

If Humana Healthy Horizons approves the subdelegation, the delegate will provide Humana Healthy Horizons documentation of a written subdelegation agreement that:

- Is mutually agreed upon
- Describes the activities and responsibilities of the delegate and the subdelegate
- Requires at least semiannual reporting of the subdelegate to the delegate
- Describes the process by which the delegate evaluates the subdelegate's performance
- Describes the remedies available to the delegate if the subdelegate does not fulfill its obligations, including revocation of the delegation agreement
- Allows Humana Healthy Horizons access to all records and documentation pertaining to monitoring and oversight of the delegated activities

- Requires the delegated functions to be performed in accordance with Humana Healthy Horizons and delegate's requirements, state and federal rules, laws and regulations and accreditation organization standards and subject to the terms of the written agreement between Humana Healthy Horizons and the delegate
- Retains Humana Healthy Horizons' 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 Healthy Horizons with documentation of such oversight prior to delegation and annually thereafter. Humana Healthy Horizons retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by Humana Healthy Horizons. Furthermore, Humana Healthy Horizons retains the right to modify, rescind or terminate, at any time, any one or all delegated activities, regardless of any subdelegation that may previously have been approved.

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

Grievances and appeals

Humana Healthy Horizons maintains all member rights and responsibility functions except in certain special circumstances. Therefore, the delegate must:

- Forward all standard member appeals/grievances to Humana Healthy Horizons within 1 business day Phone: **1-800-448-3810 (TTY: 711)**
  Fax: **1-800-949-2961**
- Forward all expedited appeals immediately upon notification/receipt
  Phone: **1-800-448-3810 (TTY: 711)**
  Fax: **1-800-949-2961**
- Provide the following information when forwarding member appeals or grievances: date and time of receipt, member information, summary of the grievance or appeal, all denial information, if applicable, and summary of any actions taken, if applicable
- Effectuate promptly the appeal decision as rendered by Humana Healthy Horizons and support any requests received from Humana Healthy Horizons in an expedited manner
- Handle 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 nonparticipating provider appeals for claim 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.

Utilization Management requirements:

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

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

- Maintain policies and procedures that address all aspects of the Utilization Management process, including a member's right to a second opinion
  - Policies and procedures must be formally reviewed, revised, dated and signed annually. Effective dates are present on policies or on a policy master list.
- Perform preadmission review and authorization, including medical necessity determinations based on approved criteria, specific benefits and member eligibility
- Perform, manage and monitor the referral process for outpatient/ambulatory care
- Determine the appropriateness of each referral to specialists, therapists, etc., as it relates to medical necessity
  - The delegate also is responsible for conducting retrospective reviews for outpatient/ambulatory care.
- Perform Utilization Management activities for out-of-service areas and out-of-network providers as dictated by the contract
- Notify the member, facility and provider of the decision on initial determinations using Humana Healthy Horizons-/CMS-approved letter templates
- Utilize Humana Health Horizons' prior authorization list (PAL)
  - If the delegate is delegated for both Utilization Management and claim payment, the delegate may develop their own PAL. However, the delegate's PAL may not be more stringent than Humana Healthy Horizons' PAL. If the delegate is not delegated to process claims on Humana Healthy Horizons' behalf, the delegate must utilize Humana Health Horizons' PAL.

- Maintain a log and submit it as required by regulatory and accreditation organization requirements
  - Humana Healthy Horizons retains the right to make the final decision regardless of contract type.
- Maintain documentation of pertinent clinical information gathered to support the decision
- Understand that all Utilization Management files and supporting documentation are Humana Healthy Horizons' property
  - Should the contract between the delegate and Humana Healthy Horizons be dissolved for any reason, the delegate is expected to make available to Humana Healthy Horizons either the original or quality copies of all Utilization Management files for Humana Healthy Horizons members.
- Provide applicable Utilization Management reporting requirements outlined within the contract and related addenda or attachments
  - Humana Healthy Horizons will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons standards. Any changes will be communicated to the delegate at such time.

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

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

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

Care management delegation

Delegation of care management must include:

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

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

Claims delegation

Claims delegation is a formal process by which a health plan gives a participating provider (delegate) the authority to process claims on its behalf. Humana Healthy Horizons' 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 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 of such claims may be charged against the delegate's funding. Refer to the contract for funding arrangement details.

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

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

- The delegate must accurately process at least 95% of all delegated claims according to Humana Healthy Horizons requirements and in accordance with your contract, state and federal laws, rules and regulations and/or any regulatory or accrediting entity to whom Humana Healthy Horizons is subject.
- The delegate must meet applicable state and/or federal requirements to which Humana Healthy Horizons is subject for denial and appeals language in all communications made to members and use Humana Healthy Horizons' member letter template.
- Since Humana Healthy Horizons does not delegate nonparticipating provider reconsideration requests, the delegate should forward all requests to Humana Healthy Horizons upon receipt.
- The delegate shall provide a financial guarantee, acceptable to Humana Healthy Horizons, prior to implementation of any delegation of claim 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 as required by state and federal rules, regulations and Humana Healthy Horizons. Refer to the Process Integration Agreement for details.
- The delegate should use and maintain a claim 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' credentialing and recredentialing requirements, all applicable state and federal laws, rules and regulations and NCQA standards and guidelines for the accreditation of Medicaid MCO requirements pertaining to credentialing and/or recredentialing. 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 is responsible for the collection and evaluation of ongoing monitoring of sanctions and complaints. In addition, Humana Healthy Horizons retains the right to approve, deny, terminate or suspend new or renewing practitioners and organizational providers from participation in any of the delegator's networks.

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

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

Chapter 4: Covered services

General services

Humana Healthy Horizons is required to arrange, through its contracted providers, the following medically necessary services for each member. In lieu of service (ILOS) is an alternative service or setting covered by Humana Healthy Horizons as a substitute or alternative to a service or setting covered under the Louisiana Medicaid state plan. In accordance with 42 CFR 438.3(e)(2), "in lieu of" are medically appropriate and cost-effective substitute services that are offered voluntarily by the MCO. A listing of all covered behavioral health services can be found in the behavioral health services section of this manual. Members will not be denied access to a medically appropriate state-plan service or setting solely based on having been offered an ILOS, currently receiving an ILOS or having received an ILOS in the past.

Service/benefit	Covered service/benefit	Limits/special instructions
23-hour observation bed services	Inpatient hospital-based intervention designed to allow for the opportunity to hold and assess a member without admission	This is an in lieu of service for members age 21 and older
APRNs	A nurse licensed as an APRN includes a: • Clinical nurse specialist (CNS) • Certified nurse practitioner (CNP) • Certified nurse midwife (CNM)	
Allergy testing and allergen immunotherapy	Testing and treatment for allergies to things like food, animals, pollen and dust mites	
Ambulatory surgical services	Outpatient surgical center for procedures that do not require an inpatient hospital stay	
Anesthesia	Anesthesia services covered when provided by an anesthesiologist or certified registered nurse anesthetist (CRNA)	

Service/benefit	Covered service/benefit	Limits/special instructions
Applied behavior analysis therapy	Focuses on improving specific behaviors, such as social skills, communication, reading and academics as well as adaptive learning skills, such as fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality and job competence	Covered for members age 0–20 Prior authorization required
Bariatric surgery	Open or laparoscopic procedures that revise the gastrointestinal anatomy to restrict the size of the stomach, reduce absorption of nutrients, or both, for weight loss; covered when determined to be medically necessary	
Breast surgery	Mastectomy, breast reconstruction, reduction mammoplasty and removal of breast implants when determined to be medically necessary	
Cardiovascular services	Elective invasive coronary angiography (ICA) and percutaneous coronary intervention (PCI) covered as treatment for cardiovascular conditions under specific circumstances	Covered for members 18 and older
Chiropractic services	Chiropractic services to diagnose and treat neuromusculoskeletal conditions associated with the functional integrity of the spine	Covered for members age 0–20 under EPSDT Covered for members age 21 and older as an in lieu of service
Cochlear implant	Includes: • Preoperative evaluation • Implants, equipment, repairs and replacements • Implantation procedure, postoperative rehabilitative costs and subsequent therapy • Postoperative programming	Covered for members age 0–20
Dental services—emergency	Services to restore a natural tooth, as best as possible, due to accidental injury	

Service/benefit	Covered service/benefit	Limits/special instructions
Diabetes self-management training (DSMT)	Training to teach members how to cope with and manage diabetes includes: • Instructions for blood glucose self-monitoring • Education regarding diet and exercise • Individualized insulin treatment plan (for insulin-dependent members) • Encouragement and support for use of self-management skills Parents or legal guardians can participate in DSMT rendered to their child.	A maximum of 10 hours of initial training (1 hour of individual and 9 hours of group sessions) are allowed during the first 12-month period beginning with the initial training date A maximum of 2 hours of individual sessions allowed for each subsequent year
Doula services	Physical, emotional and educational support to supplement pregnancy and postpartum health care services and support pregnant enrollees to receive healthy, safe and equitable prenatal and postnatal care	Prenatal visits: 5 visits for up to 90-minute sessions Support and assistance during labor and childbirth: 1 visit Postpartum visits: 3 visits for up to 90-minute sessions
Durable medical equipment (DME), prosthetics, orthotics and certain supplies	Medical equipment, supplies or devices primarily and customarily used for medical purposes and not generally useful in the absence of illness or injury	Prior authorization may be required. Refer to the Humana Healthy Horizons PAL for services requiring prior authorization.

Service/benefit	Covered service/benefit	Limits/special instructions
EPSDT services	• Complete health and developmental history • Unclothed physical exam • Laboratory tests (including lead screening) • Immunizations (shots) • Screenings (including mental health, depression, substance use, development, hearing, vision, lead, other) • Dental screenings and referrals to dental providers • Nutrition • Health education and guidance • Referrals for further diagnosis (testing) and treatment when needed • Vision services • Dental services • Hearing services	Covered for members age 0–20
Emergency and poststabilization services	• Emergency service and care • Poststabilization care after an emergency	Emergency services and poststabilization care covered for out-of-state or out-of-network providers until safe discharge or transfer to an in-state facility is medically appropriate.
End-stage renal disease services	• Renal dialysis treatments (hemodialysis and peritoneal dialysis) • Routine laboratory services • Nonroutine laboratory services • Medically necessary injections	

Service/benefit	Covered service/benefit	Limits/special instructions
Eye care and vision services	Members 0 through 20: • Examinations and treatment of eye conditions, including examinations for vision correction, refraction error • Regular eyeglasses when they meet a certain minimum strength requirement; medically necessary specialty eyewear and contact lenses with prior authorization; contact lenses covered if they are the only means for restoring vision Members 21 and over: • Examinations and treatment of eye conditions such as infections, cataracts, etc. • If the recipient has both Medicare and Medicaid, some vision-related services may be covered. The recipient should contact Medicare for more information since Medicare would be the primary payer. • Contact lenses covered if they are the only means for restoring vision	
Family planning services	• Evaluation and management • Diagnostic services – Contraceptive services – Implantable contraceptive capsules – Diaphragm – Intrauterine contraceptives – Contraceptive supplies – Injectable contraceptives – Oral contraceptives	Covered for members age 10–59

Service/benefit	Covered service/benefit	Limits/special instructions
Freestanding psychiatric hospital for adults	Services received in an Institution for Mental Disease (IMD)	Offered by Humana Healthy Horizons as an in lieu of service for members age 21 to 64 and suffering from substance use disorder (SUD) Not to exceed 30 days
FQHC/RHC services	• Provider services • Services and supplies incident to a provider's professional services • Physician assistant services • Nurse practitioner and nurse midwife services • Services and supplies incident to provider assistant, nurse practitioner and nurse midwife services • Visiting nurse services to the homebound • Clinical psychologist • Clinical social worker services • Services and supplies incident to the services of clinical psychologists and clinical social workers • Other ambulatory services • Diabetes self-management training • Fluoride varnish applications	
Freestanding psychiatric hospitals for adults	• Medically necessary psychiatric inpatient care at freestanding psychiatric units	Offered by Humana Healthy Horizons as an "in-lieu-of" service; prior authorization required

Service/benefit	Covered service/benefit	Limits/special instructions
Genetic counseling and testing	• Genetic counseling • Breast and ovarian cancer • Familial adenomatous polyposis • Lynch syndrome	
Gynecology	Area of medicine involving the treatment of women's diseases, especially those of the reproductive organs, including: • Hysterectomies • Long-acting reversible contraceptives • Mammograms • Pap tests • Pelvic examinations • Saline infusion sonohysterography or hysterosalpingography	
Home health services	• Skilled nursing services • Home health aide services • Physical therapy • Occupational therapy • Speech-language pathology services • Intermittent skilled nursing • Extended home health (EHH) services • Extended skilled nursing services	Birth through age 20: no annual service limits Age 21 and older: 1 visit per profession per day
Hospital-based care coordination of pregnant and postpartum individuals with SUD and their newborns	Coverage for a comprehensive pregnancy medical home model of care to Humana Healthy Horizons members with SUD, who are 18 years of age and older and pregnant or up to 12 months postpartum	Offered by Humana Healthy Horizons as an in lieu of service for members age 21 and older
Hospice services	Comfort care for patients who are terminally ill, provided in their home or in a hospice facility when the member has elected hospice	

Service/benefit	Covered service/benefit	Limits/special instructions
Hospital services—inpatient	Care needed for the treatment of an illness or injury that can only be provided safely and adequately in a hospital setting and includes those basic services a hospital is expected to provide	
Hospital services outpatient	Care provided in an outpatient hospital setting for less than 24 hours	
Hyperbaric oxygen therapy	Treatments administered in a hyperbaric oxygen therapy chamber if deemed medically necessary	
Injection services provided by licensed nurses to adults	Allows licensed nurses to administer injections instead of providers	Offered by Humana Healthy Horizons as an in lieu of service for members age 21 and older
Immunizations	Vaccines for members age 0–18 are covered when recommended by the Advisory Committee on Immunization Practices (ACIP). These vaccines are provided free of charge through the Louisiana Immunization Program/ Vaccines for Children Program. For members age 19 and older, all ACIP-recommended vaccines and vaccine administration are covered according to ACIP recommendations.	Limitations apply depending on member's age
Intrathecal baclofen therapy	Used to help relax certain muscles in the body, relieving the spasms, cramping and tightness caused by medical issues such as multiple sclerosis, cerebral palsy or certain injuries to the spine	Age 4 and older
Laboratory services	Most diagnostic testing and radiological services ordered by the attending or consulting provider Portable (mobile) X-rays covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain provider-ordered X-rays	

Service/benefit	Covered service/benefit	Limits/special instructions
Medical transportation services	Transportation to and from Medicaid-covered service appointments	Managed by MediTrans, 1-844-613-1638, Monday – Friday, 7 a.m. – 7 p.m.
Mental health intensive outpatient programs	Mental health services that include intensive outpatient (treatment program that operates at least 3 hours a day, 3 days a week, and is based on an individualized treatment plan), including assessment and counseling, crisis intervention and activity therapies or education	Offered by Humana Healthy Horizons as an in lieu of service for members age 12 and older
Newborn care and discharge	Educating new parents and caregivers on newborn care and safety, including • Discharge services • Newborn screenings for genetic disorders • Screening of all newborns for early detection of cytomegalovirus (CMV) infection	
Obstetrics	Field of study concentrated on pregnancy, childbirth and the postpartum period, including: • Initial prenatal visit(s) • Follow-up prenatal visits • Postpartum care visit • Prenatal laboratory and ultrasound services	
Organ transplants	Medically necessary organ transplants covered when performed in a hospital that is a Medicaid-approved transplant center for that procedure	

Service/benefit	Covered service/benefit	Limits/special instructions
Outpatient lactation support	Coverage of outpatient lactation support services for members who are breastfeeding or exclusively pumping	6 total treatment sessions that occur during pregnancy or while less than 24 months postpartum Individual sessions: 60-minute minimum session length Group sessions: Up to a maximum of 8 participants in a group session with a 60minute minimum session length
Pediatric day healthcare services	Services include: • Nursing care • Respiratory care • Physical therapy • Speech-language therapy • Occupational therapy • Social services • Personal care services (activities of daily living [ADL]) • Transportation to and from the pediatric day healthcare facility, paid in a separate per diem	Covered for members age 0–20 when medically necessary

Service/benefit	Covered service/benefit	Limits/special instructions
Personal care services	Provision of medically necessary assistance, in the home or in the community, with ADL and age-appropriate instrumental ADL (IADL) to enable members to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability, including: • Basic personal care toileting and grooming activities • Assistance with bladder and/or bowel requirements or problems • Assistance with eating and food preparation • Performance of incidental household chores, only for the recipient • Accompanying, not transporting, recipient to medical appointments	Covered for members age 0–20 when medically necessary
Pharmacy services	Medicine used to promote healing	
Physician-administered medication	Outpatient drug other than a vaccine that is typically administered by a healthcare provider in a provider's office or other outpatient clinical setting	
Provider/professional services	Professional services are provided by, but are not limited to: • Provider services • Nurse midwife • Nurse practitioner • CNSs • Physician assistant • Certain family planning services are covered when provided in a provider's office • Telemedicine/Telehealth	

Service/benefit	Covered service/benefit	Limits/special instructions
Podiatry services	Medical care and treatment of the foot • Office visits • Certain radiology and lab procedures and other diagnostic procedures	
Portable X-ray services	Portable X-rays for members who are unable to travel to a provider's office or outpatient hospital's radiology facility Covered radiographs are limited to: • Skeletal films of a member's limbs, pelvis, vertebral column or skull • Chest films that do not involve the use of contrast media • Abdominal films that do not involve the use of contrast media	
Preventive services for adults	Screenings, checkups, vaccinations and member counseling, from primary care providers or specialists, to prevent illness, disease or other health problems	Covered for members 21 and older
Routine care provided to members participating in clinical trials	Any item or service provided to a member participating in a qualifying clinical trial to the extent that the item or service would otherwise be covered for the member when not participating in the qualifying clinical trial, including any item or service provided to prevent, diagnose, monitor or treat complications resulting from participation	
Radiology services	Radiology includes: • X-ray (with or without contrast) • MRI (with or without dye) • CT/CAT scan • Magnetic angiography and imaging • Radiographic exams • Ultrasound (endoscopic, echography, breast, abdominal, kidney, uterus, elastography)	

Service/benefit	Covered service/benefit	Limits/special instructions
Sinus procedures	Balloon ostial dilation and functional endoscopic sinus surgery considered medically necessary for the treatment of chronic rhinosinusitis when the member meets the necessary criteria	
Skilled nursing facility	Nursing facilities services, with the exception of postacute rehabilitation care	Offered by Humana Healthy Horizons as an in lieu of service
Skin substitutes for chronic diabetic lower extremity ulcers	Humana Healthy Horizons shall cover skin substitutes and consider them to be medically necessary for the treatment of partial and full-thickness diabetic lower extremity ulcers when the member meets the necessary criteria	
Sterilization	Medically necessary procedure to permanently render a member incapable of reproducing	Age 21 and older
Therapy services	Therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments • Audiological services (available only in rehabilitation clinic and hospitaloutpatient settings) • Occupational therapy • Physical therapy • Speech-language therapy	

Service/benefit	Covered service/benefit	Limits/special instructions
Tobacco cessation services	Smoking cessation treatments and services, including individual counseling, group counseling, nicotine patches, nicotine gum, nicotine lozenges, nicotine nasal spray, nicotine inhaler, bupropion and varenicline	Coverage for a minimum of 6 months Up to 4 tobacco cessation counseling sessions per quit attempt Up to 2 quit attempts per calendar year For a max of 8 sessions per calendar year Limits may be exceeded if medically necessary
Vagus nerve stimulators (VNSs)	Medical treatment that involves delivering electrical impulses to the vagus nerve, used as an add-on treatment for certain types of intractable epilepsy and treatment-resistant depression, including: • VNS • Implantation of VNS • Programming of VNS • Battery replacement	For members age 12 years and older, although case by case consideration may be given to younger children who meet all other criteria and have sufficient body mass to support the implanted system

Allergy testing and allergen immunotherapy

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

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

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

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

Cardiovascular services

Humana Healthy Horizons covers elective invasive coronary angiography (ICA) and percutaneous coronary intervention (PCI) as treatment for cardiovascular conditions under specific circumstances.

The following are not eligible for these services:

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

Eligibility criteria for elective ICA

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

- Congenital heart disease that cannot be characterized by noninvasive modalities such as cardiac ultrasound, CT scan or MRI
- Heart failure with reduced ejection fraction for the purposes of diagnosing ischemic cardiomyopathy
- Hypertrophic cardiomyopathy prior to septal ablation or myomectomy
- Severe valvular disease or valvular disease with plans for surgery or percutaneous valve replacement
- Type 1 myocardial infarction within the past 3 months defined by detection of a rise and/or fall of cardiac troponin values with at least 1 value above the 99th percentile upper reference limit and with at least 1 of the following:
  - Symptoms of acute myocardial ischemia
  - New ischemic electrocardiogram (ECG) changes
  - Development of pathological Q waves
  - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality in a pattern consistent with an ischemic etiology
  - Identification of a coronary thrombus
- History of ventricular tachycardia requiring therapy for termination or sustained ventricular tachycardia not due to a transient reversible cause, within the past year

- History of ventricular fibrillation
- Return of angina within 9 months of prior PCI
- Canadian Cardiovascular Society (CCS) class I–IV classification of angina, without chronic kidney disease, with intolerance of or failure to respond to at least 2 target doses antianginal medications (beta blockers, dihydropyridine or nondihydropyridine calcium channel blockers, nitrates and/or ranolazine)
- High-risk imaging findings, defined as 1 or more of the below:
  - Severe resting left ventricular dysfunction (LVEF ≤ 35%) not readily explained by noncoronary causes
  - Resting perfusion abnormalities ≥ 10% of the myocardium in members without prior history or evidence of myocardial infarction
  - Stress ECG findings including ≥2 mm of ST-segment depression at low workload
  - Persisting into recovery, exercise-induced ST-segment elevation or exercise-induced ventricular tachycardia/ ventricular fibrillation
  - Severe stress-induced left ventricular dysfunction (peak exercise LVEF < 45% or drop in LVEF with stress ≥ 10%)
  - Stress-induced perfusion abnormalities affecting ≥ 10% myocardium or stress segmental scores indicating multiple vascular territories with abnormalities
  - Stress-induced left ventricular dilation
  - Inducible wall motion abnormality (involving > 2 segments or 2 coronary beds)
  - Wall motion abnormality developing at a low dose of dobutamine (≥ 10 mg/kg/min) or at a low heart rate (< 120 beats per minute)
  - Left main stenosis (≥ 50% stenosis) on coronary computed tomography angiography
  - ICA for non-acute, stable coronary artery disease is not considered medically necessary, including for patients with stable angina who are not interested in revascularization or who are not candidates for PCI or coronary artery bypass graft surgery.

Eligibility criteria for elective PCI

Humana Healthy Horizons covers elective PCI for angina with stable coronary artery disease and considers it medically necessary in members without chronic kidney disease who have CCS class I–IV angina with intolerance of or failure to respond to at least two target doses antianginal medications (beta blockers, dihydropyridine or nondihydropyridine calcium channel blockers, nitrates and/or ranolazine).

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

- Heart failure with reduced ejection fraction for the purposes of treating ischemic cardiomyopathy

- Left main stenosis ≥ 50% as determined on prior cardiac catheterization or coronary computed tomography angiography, if the member has documentation indicating the member was declined for a coronary artery bypass graft surgery
- Type 1 myocardial infarction within the past 3 months as defined by detection of a rise and/or fall of cardiac troponin values with at least 1 value above the 99th percentile upper reference limit and with at least 1 of the following:
  - Symptoms of acute myocardial ischemia
  - New ischemic ECG changes
  - Development of pathological Q waves
  - Imaging evidence of a new loss of viable myocardium or new regional wall motion abnormality in a pattern consistent with an ischemic etiology
  - Identification of a coronary thrombus

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

Endovascular revascularization for peripheral artery disease

Humana Healthy Horizons covers endovascular revascularization procedures (stents, angioplasty and atherectomy) for the lower extremity and considers them medically necessary for the following conditions:

- Acute limb ischemia
- Chronic limb-threatening ischemia, defined as the presence of any of the following:
  - Ischemic pain at rest
  - Gangrene
  - Lower limb ulceration greater than 2 weeks duration

Humana Healthy Horizons also covers endovascular revascularization procedures and considers them medically necessary in members with peripheral artery disease who have symptoms of intermittent claudication and meet all of the following criteria:

- Significant peripheral artery disease of the lower extremity as indicated by at least 1 of the following:
  - Moderate to severe ischemic peripheral artery disease with an ankle-brachial index (ABI) ≤ 0.69
  - Stenosis in the aortoiliac artery, femoropopliteal artery, or both arteries, with a severity of stenosis ≥ 70% by imaging studies
- Claudication symptoms that impair the ability to work or perform ADL
- No improvement of symptoms despite all of the following treatments:
  - Documented participation in a medically supervised or directed exercise program for at least 12 weeks

  - Individuals unable to fully perform exercise therapy may qualify for revascularization only if the procedure is expected to provide long-term functional benefits despite the limitations that precluded exercise therapy.
- At least 6 months of optimal pharmacologic therapy including all of the below agents, unless contraindicated or discontinued due to adverse effects:
  - Antiplatelet therapy with aspirin, clopidogrel, or both
  - Statin therapy
  - Cilostazol
  - Antihypertensives to a goal systolic blood pressure ≤ 140 mmHg and diastolic blood pressure ≤ 90 mmHg
- At least 1 documented attempt at smoking cessation, if applicable, consisting of pharmacotherapy, unless contraindicated, and behavioral counseling, or referral to a smoking cessation program that offers both pharmacotherapy and counseling

Exclusions

Humana Healthy Horizons does not consider endovascular revascularization procedures for the lower extremity medically necessary in the following circumstances:

- Claudication due to isolated infrapopliteal artery disease (anterior tibial, posterior tibial or peroneal) including members with coronary artery disease, diabetes, or both
- To prevent the progression of claudication to chronic limb-threatening ischemia in a member who does not otherwise meet medical necessity criteria
- Member is asymptomatic
- Treatment of a nonviable limb

Peripheral arterial disease rehabilitation for symptomatic peripheral arterial disease

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

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

Cochlear implant

Humana Healthy Horizons covers unilateral or bilateral cochlear implants for members under 21 years of age when deemed medically necessary for treatment of severe-to-profound, bilateral sensorineural hearing loss. Implants must be used in accordance with FDA guidelines.

Eligibility criteria

A multidisciplinary implant team must collaborate to determine eligibility and provide care. This team must include, at minimum, a fellowship-trained pediatric otolaryngologist or fellowship trained otologist, an audiologist and a speech-language pathologist.

An audiological evaluation must find:

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

A medical evaluation must include:

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

For bilateral cochlear implants, an audiologic and medical evaluation must determine that a unilateral cochlear implant plus hearing aid in the contralateral ear will not result in binaural benefit for the member.

Nonaudiological evaluations must include:

- Speech and language evaluation to determine the member's level of communicative ability
- Psychological and/or social work evaluation, as needed

Preoperative counseling must be provided to the member, if age appropriate, and the member's caregiver and must provide:

- Information about implant components and function; risks, limitations and potential benefits of implantation; the surgical procedure; and a postoperative follow-up schedule
- Appropriate post-implant expectations, including being prepared and willing to participate in pre- and post-implant assessment and rehabilitation programs
- Information about alternative communication methods to cochlear implants

Preoperative evaluation

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

Implants, equipment, repairs and replacements

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

Humana Healthy Horizons covers:

- All costs for upgrades and repairs to the component parts of the implant
- All costs for cords and batteries

Implantation procedure, postoperative rehabilitative costs and subsequent therapy

Humana Healthy Horizons covers the cochlear implant surgery as well as postoperative aural rehabilitation by an audiologist and subsequent speech, language and hearing therapy.

Postoperative programming

Humana Healthy Horizons covers cochlear implant postoperative programming and diagnostic analysis services.

Noncovered expenses

The following items are non-covered expenses:

- Service contracts and/or extended warranties
- Insurance to protect against loss and theft

Community health workers

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

A qualified CHW is defined as someone who:

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

Eligibility criteria

Humana Healthy Horizons covers CHW services if a member has 1 or more of the following:

- Diagnosis of 1 or more chronic health (including behavioral health) conditions

- Suspected or documented unmet health-related social need(s)
- Pregnancy

Covered services include:

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

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

Humana Healthy Horizons will not restrict the site of service, which may include, but is not limited to, a healthcare facility, clinic setting, community setting or the member's home. The health plan will permit delivery of the service through a synchronous audio-video telehealth modality. Humana Healthy Horizons will reimburse only the applicable codes that are provided by CHWs. The CHWs are required to follow CPT guidance.

Coverage limitations

Humana Healthy Horizons does not cover the following services when provided by CHWs:

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

Humana Healthy Horizons will reimburse a maximum of 2 hours per day and 10 hours per month per member.

Reimbursement

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

Donor human milk

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

- The hospitalized infant is less than 12 months of age with 1 or more of the following conditions:
  - Prematurity
  - Malabsorption syndrome
  - Feeding intolerance
  - Immunologic deficiency
  - Congenital heart disease or other congenital anomalies
  - Other congenital or acquired condition that places the infant at high risk of developing necrotizing enterocolitis (NEC) and/or infection
- The infant's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support or has a contraindication to breastfeeding.
- The infant's caregiver has received education on donor human milk, including the risks and benefits, and agrees to the provision of donor human milk to the infant.
- The donor human milk is obtained from a milk bank accredited by, and in good standing with, the Human Milk Banking Association of North America.

Reimbursement

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

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

EPSDT services

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

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

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

General anesthesia/facility reimbursement for dental treatment

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

Reimbursement

- Anesthesia providers will receive an additional reimbursement of $20 per time unit (each time unit is equal to 15 minutes).
- To receive the additional reimbursement, the provider must append modifier 23 to the anesthesia CPT code 00170 in addition to other appropriate anesthesia modifiers when a dental procedure is performed.
- The general anesthesia reimbursement formula has been revised to calculate the additional reimbursement.
- Facilities can receive an additional reimbursement of at least $400 per procedure.
- For hospital providers to receive the additional reimbursement, CPT code 41899 must be used. To qualify for the enhanced reimbursement, the procedure must take place in a hospital outpatient setting.

Pain management

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

For chronic intractable pain, coverage is dependent on the clinical etiology and the type of service or treatment.

Genetic counseling and testing

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

Genetic counseling

In alignment with LDH policy, Humana Healthy Horizons requires counseling before and after all genetic testing. Counseling must consist of at least all of the following and be documented in the member's medical record:

- Obtaining a structured family genetic history

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

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

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

Breast and ovarian cancer

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

Eligibility criteria

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

- Has any blood relative with a known BRCA1/BRCA2 mutation
- Meets the criteria below but with previous limited testing (e.g., single gene and/or absent deletion duplication analysis) interested in pursuing multigene testing
- Has a personal history of cancer, defined as one of more of the following:
  - Breast cancer and 1 or more of the following:
  - Diagnosed at age 45 or younger
  - Diagnosed at age 45–50 with:
  - Unknown or limited family history
  - A second incidence of breast cancer diagnosed at any age
  - At least 1 close blood relative with breast, ovarian, pancreatic or high-grade (Gleason score of at least 7) or intraductal prostate cancer at any age
- Diagnosed with triple negative breast cancer at age 60 or younger
- Diagnosed at any age with:
  - Ashkenazi Jewish ancestry
  - At least 1 close blood relative with breast cancer at under 50 years of age or ovarian, pancreatic or metastatic or intraductal prostate cancer at any age
  - At least 3 total diagnoses of breast cancer in patient and/or close blood relatives
- Diagnosed at any age with male breast cancer
- Diagnosed with epithelial ovarian cancer (including fallopian tube cancer or peritoneal cancer) at any age

- Exocrine pancreatic cancer at any age
- Metastatic or intraductal prostate cancer at any age
- High-grade (Gleason score of at least 7) prostate cancer at any age with:
  - Ashkenazi Jewish ancestry
  - At least 1 close blood relative with breast cancer diagnosed at age 50 or younger, or ovarian, pancreatic or metastatic or intraductal prostate cancer at any age
  - At least 2 close blood relatives with breast or prostate cancer (any grade) at any age
- A mutation identified on tumor genomic testing that has clinical implications if also identified in the germ line
- To aid in systemic therapy decision making, such as for HER2-negative metastatic breast cancer
- Has a family history of cancer, including unaffected individuals, defined by 1 or more of the following:
  - An affected or unaffected individual with a 1st- or 2nd-degree blood relative meeting any of the criterion listed above (except individuals who meet criteria only for systemic therapy decision making)
  - An affected or unaffected individual who otherwise does not meet criteria above but also has a probability > 5% of a BRCA1/BRCA2 pathogenic variant based on prior probability models (e.g., Tyrer-Cuzick, BRCAPRO, Penn II)

Prenatal visits

Humana Healthy Horizons covers 2 initial prenatal visits per pregnancy (270 days). These 2 visits may not be performed by the same attending provider.

Humana Healthy Horizons will consider the member a “new patient” for each pregnancy whether or not the member is a new or established patient to the provider/practice. Humana Healthy Horizons requires billing the appropriate level Evaluation and Management (E&M) CPT code with the TH modifier for the initial prenatal visit. A pregnancy-related diagnosis code also must be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, includes, but is not limited to, the following:

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

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

Obstetric ultrasounds

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

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

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

Prenatal services should be billed with a TH modifier.

Fetal nonstress test

Humana Healthy Horizons covers fetal nonstress tests when medically necessary as determined by meeting 1 of the following criteria:

- The pregnancy is postdate/postmaturity (after 41 weeks gestation)
- The treating provider suspects potential fetal problems in an otherwise normal pregnancy
- The pregnancy is high risk, including but not limited to diabetes, preeclampsia, eclampsia, multiple gestations and previous intrauterine fetal death

Fetal biophysical profile

Humana Healthy Horizons covers fetal biophysical profiles when medically necessary, as determined by meeting at least 2 of the following criteria:

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

Pharmacy services

You can find a more comprehensive description of covered services at **Humana Drug Lists for providers**.

Provider/professional services

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

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

Sinus procedures policy

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

- Uncomplicated chronic rhinosinusitis limited to the paranasal sinuses without the involvement of adjacent neurological, soft tissue or bony structures that has persisted for at least 12 weeks with at least 2 of the following sinonasal symptoms:
  - Facial pain/pressure
  - Hyposmia/anosmia
  - Nasal obstruction
  - Mucopurulent nasal discharge
- Sinonasal symptoms that are persistent after maximal medical therapy has been attempted, as defined by all of the following, either sequentially or overlapping:
  - Saline nasal irrigation for at least 6 weeks
  - Nasal corticosteroids for at least 6 weeks
  - Approved biologics, if applicable, for at least 6 weeks
  - A complete course of antibiotic therapy when an acute bacterial infection is suspected
  - Treatment of concomitant allergic rhinitis, if present
- Objective evidence of sinonasal inflammation as determined by 1 of the following:
  - Nasal endoscopy
  - Computed tomography

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

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

Skin substitutes for chronic diabetic lower extremity ulcers

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

- A lower extremity ulcer is present:
  - Is at least 1 square cm in size

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

The beneficiary must not have any of the following:

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

Coverage limitations

The following coverage limitations apply:

- Coverage is limited to a maximum of 10 treatments within a 12-week period.
- If there is no measurable decrease in surface area or depth after 5 applications, then further applications are not covered.
- For all ulcers, a comprehensive treatment plan must be documented, including at least all of the following:
  - Offloading of weight
  - Smoking cessation counseling and/or medications, if applicable

  - Edema control
  - Improvement in diabetes control and nutritional status
  - Identification and treatment of other comorbidities that may affect wound healing such as ongoing monitoring for infection
- While providers may change products used for the diabetic lower extremity ulcers, simultaneous use of more than 1 product for the diabetic lower extremity ulcers is not covered.
- Hyperbaric oxygen therapy is not covered when used at the same time as skin substitute treatment.

Prior authorization

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

Note: If there is no measurable decrease in surface area or depth after 5 applications, then further applications are not covered, even when preauthorized.

Sterilization

Coverage requirements

In accordance with federal regulations, Humana Healthy Horizons covers sterilizations if the following requirements are met:

- The individual is at least 21 years of age at the time consent is obtained.
- The individual is mentally competent.
- The individual has voluntarily given informed consent in accordance with all federal requirements.
- At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since a member gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

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

Sterilization consent form requirements

Humana Healthy Horizons directs providers to use the current sterilization consent forms (HHS-687 available in English and HHS-687-1 available in Spanish) from the U.S. Department of Health and Human Services website.

Humana Healthy Horizons requires the consent form to be signed and dated by:

- The individual to be sterilized
- The interpreter, if one was provided

- The person who obtained the consent
- The provider performing the sterilization procedure

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

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

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

Consent forms and name changes

For services requiring a sterilization consent form, the member's name on the Medicaid file for the date of service must be the same as the name signed at the time of consent. If the member's name is different, the provider must attach a letter from the provider's office from which the consent was obtained. The letter must be signed by the provider, state that the member's name has changed and include the member's Social Security number and date of birth. It is Humana Healthy Horizons' responsibility to ensure required documentation is maintained by the provider.

Correcting the sterilization consent form

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

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

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

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

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

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

Reimbursement

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

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

Telemedicine/telehealth

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

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

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

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

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

Tobacco cessation services

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

Humana Healthy Horizons covers up to 4 tobacco cessation counseling sessions per quit attempt and up to 2 quit attempts per calendar year, for a maximum of 8 counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

Minimum reimbursement for tobacco cessation counseling is based on the applicable CPT code on the Professional Services Fee Schedule and must be supported by appropriate documentation.

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

Urine drug testing

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

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

Behavioral health services

Behavioral health services are covered for Humana Healthy Horizons members.

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

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

- Basic behavioral health services: Services provided through primary care including, but not limited to, screening for mental health and substance use issues, prevention, early intervention, and medication management as well as treatment and referral to specialty services.
- Specialized behavioral health services:
  - LMHP services provided by licensed medical psychologists, licensed psychologists, LCSWs, LPCs, licensed marriage and family therapists (LMFTs, licensed addiction counselors (LACs and APRNs)
- Community Psychiatric Support & Treatment (CPST) (all ages)

- Psychosocial Rehabilitation (PSR) (all ages)
- Crisis Intervention (CI) (all ages)
- Assertive Community Treatment (ACT) (age -18 and older)
- Crisis Responses Services
    a. Mobile Crisis Response (MCR) (all ages)
    b. Behavioral Health Crisis Care (BHCC) (age 18 and older)
    c. Community Brief Crisis Service (CBCS) (all ages)
    d. Crisis Stabilization (CS) (all ages)
- Individual Placement and Supports (IPS) (age 18 and older)
- Personal Care Services (PCS) (age 21 and older)
- Peer Support Services (PSS) (age 21 and older)
- Outpatient Therapy with Licensed Practitioners (including but not limited to medication management, individual, family, and group counseling) (all ages)
- Addiction Services (outpatient and residential)
- Psychiatric Inpatient Hospital (age 18 to 21 years and over 65)
- Psychiatric Residential Treatment Facility (PRTF) (age under 21)
- Opioid Treatment Programs (OTPs) (age 18 and older)
- Therapeutic Group Home (age under 21)
- Multi-systemic Therapy (MST) (age range 12 to 17)
- Functional Family Therapy (FFT) (age 10 to 18)
- Homebuilders (HB) (age birth to 18)
- Child Parent Psychotherapy (CPP) (ages birth to 6)
- Parent-child interaction therapy (PCIT)
- Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (age 3 to 18)
- Eye Movement Desensitization and Reprocessing (EMDR) Therapy (age 2 to adult)
- Federally Qualified Health Center (FQHC)

Humana Healthy Horizons' network focuses on improving member health through evidence-based practices. Our goal is to provide the level of care needed by the member within the safest least restrictive setting.

Screening and evaluation

Humana Healthy Horizons 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 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 also offers chronic condition management programs for mental health and substance use, as well as care management programs based on a member's level of need (see **Chapter 12: Care management programs** in this manual). Call **1-800-448-3810 (TTY: 711)** to refer members needing care management assistance. If you prefer, email **LAMCDCaseManagement@humana.com**.

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

Continuation of treatment

Humana Healthy Horizons 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 7 days of the discharge date. Behavioral healthcare providers are expected to contact patients within 24 hours of a missed appointment to reschedule.

Emergency services and poststabilization services

An emergency medical condition is not defined based on diagnosis code or symptomology alone. An emergency medical condition is one manifesting itself via acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, for a pregnant person, the health of the individual or the unborn child) in serious jeopardy, serious impairment to bodily functions and/or serious dysfunction of any bodily organ or part.

Inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition are covered. Services that meet the emergency and

poststabilization service definitions or emergency services that are obtained at the direction of a representative of Humana Healthy Horizons are covered for members regardless of whether the provider is contracted with Humana Healthy Horizons.

The attending emergency physician, or the provider treating the member, is responsible for determining when the member is stabilized for transfer or discharge.

Humana Healthy Horizons will not deny payment for emergency services based on the provider or fiscal agent not notifying the member's PCP or Humana Healthy Horizons within 10 calendar days of presentation for emergency services.

Emergency and nonemergency medical transportation (NEMT)

For emergency transportation services, call 911.

If a member requires nonemergency transportation to a healthcare appointment or pharmacy immediately following a doctor visit, the member may call MediTrans at **1-844-613-1638**. Humana Healthy Horizons 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.

NEMT and nonemergency ambulance transportation providers will pick up members no later than 3 hours after notification by an inpatient facility of a scheduled discharge or 2 hours after the scheduled discharge time, whichever is later.

Excluded services

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

Information relating to these excluded service programs may be accessed by Humana Healthy Horizons 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 LDH may elect to cover. Humana Healthy Horizons is not required to cover services that Louisiana Medicaid has elected not to cover.

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

- Adult dental services with the exception of surgical dental services and emergency dental services
  - For additional adult dental services offered by Humana Healthy Horizons, see **Chapter 14: Value-added benefits**.
- Services to individuals in intermediate care facilities for individuals with developmental disabilities (ICFs/IDDs)

- Nursing facility services, with the exception of post-acute rehabilitative care, provided at the discretion of the contractor when it is cost effective to do so in place of continued inpatient care as an in lieu of service
- Individualized education plan (IEP) services, including physical, occupational and speech-language therapy, audiology and some psychological therapy, provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by Office of Public Health [OPH]-certified, school-based health clinics)
- All home- and community-based waiver services
- Targeted case management services
- Services provided through LDH's EarlySteps program (Individuals with Disabilities Education Act [IDEA], Part C program services)

The following are excluded drugs:

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

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

- Any service (drug, device, procedure or equipment) that is not medically necessary
- Experimental/investigational drugs, devices, procedures or equipment, unless approved by the LDH secretary
- 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 (PPCs) as below:
  - PPCs are defined in 2 categories:
  - Healthcare-acquired condition (HCAC), meaning a condition occurring in any inpatient hospital

setting, identified as a hospital-acquired condition (HAC) in accordance with 42 CFR 447.26

- Other provider preventable condition (OPPC), meaning a condition occurring in any healthcare setting in accordance with 42 CFR 447.26

Out-of-network care when services are unavailable

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

All out-of-network and out-of-state provider services require prior authorization unless services are required to treat an emergency medical condition.

Sterilization

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

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

Chapter 5: Utilization Management

Utilization Management helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members. Utilization review determinations are based on medical necessity, appropriateness of care and service and existence of coverage. Humana Healthy Horizons does not reward providers or our staff for denying coverage or services. There are no financial incentives for Humana Healthy Horizons' staff to encourage decisions that result in underutilization. Humana Healthy Horizons 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 establishes measures designed to maintain quality of services and control costs that are consistent with our responsibility to our members. We place appropriate limits on a service on the basis of criteria applied under the Medicaid state plan and applicable regulations, such as medical necessity. Humana Healthy Horizons 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 Utilization Management department performs all Utilization Management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the Humana Healthy Horizons Care Management team are made, if needed.

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

Criteria

Humana Healthy Horizons currently uses Milliman Care Guidelines (MCG) and the American Society of Addiction Medicine (ASAM), nationally recognized, evidence-based clinical Utilization Management criteria, as well as Humana Healthy Horizons clinical policies, to make medical necessity determinations of inpatient acute, behavioral health, rehabilitation and skilled nursing facility admissions. These guidelines are intended to allow Humana Healthy Horizons 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 providers related to medically appropriate care and treatment.

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

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

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

The guidelines used to make medical necessity determinations can be requested by sending an email to **LAMCDCriteriaRequest@humana.com**.

Humana Healthy Horizons defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. Humana Healthy Horizons 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' medical director for further review and determination.

Access to staff

Providers can email the Utilization Management staff with any Utilization Management questions or for help with discharge planning.

Medical health inquires: **LAMCDMedicalUM@humana.com**

Behavioral health inquiries: **LAMCDBehavioralHealthUM@humana.com**

Providers can also call Provider Services at **1-800-448-3810 (TTY: 711)** and request assistance with discharge planning from the Utilization Management staff.

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

- Staff members are available 24 hours a day, 7 days a week.
- Staff members can receive inbound communication regarding Utilization Management issues after normal business hours.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding Utilization Management issues.
- Staff members are available to respond to email inquiries regarding Utilization Management issues.
- Staff members are accessible to answer questions about the Utilization Management process.
- In the best interest of our members and to promote positive healthcare outcomes, Humana Healthy Horizons 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 provider reviewer, the request needs to be made within 5 calendar days from the adverse determination date. To request a peer-to-peer discussion, please send an email to **LAMCDP2PRequest@humana.com** or call **1-800-448-3810 (TTY: 711)**.

Referrals

Humana Healthy Horizons members can see any participating network provider, including specialists and inpatient hospitals. Humana Healthy Horizons 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 Medicaid network
  - If not, prior authorization must be obtained.
- Must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained
- Must be in an appropriate specialty area
- Must be enrolled in Louisiana Medicaid through the **provider enrollment portal**.
  - If enrollment cannot be validated or is incomplete, providers risk not being paid.
  - Providers unsure of their enrollment status or who want to check their status may use the **provider portal enrollment lookup tool**.
  - Results will show the provider's status as either enrollment complete, action required, application not submitted or currently in process. Providers not shown in the results are not required to enroll at this time. Invitation letters for those providers will be sent at a later date. The lookup tool is updated daily.
  - Providers needing assistance with application and enrollment should contact Gainwell Technologies by emailing **LouisianaProvEnroll@gainwelltechnologies.com** or calling **1-833-641-2140** for a status update on enrollment and any next steps needed to complete the process.

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

Release due to ethical reasons

Providers are not required to perform any treatment or procedure contrary to their conscience, religious beliefs or ethical principles, in accordance with 45 CFR 88.

Prior authorizations

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

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

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

Concurrent/inpatient authorizations

Humana Healthy Horizons requires the provider to submit notification to Humana Healthy Horizons of all inpatient admissions within 1 business day of the date of admission. Humana Healthy Horizons also requires the provider to submit notification to Humana Healthy Horizons of obstetrical admissions that exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery.

Common observation policy

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

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

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

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

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

Prior authorization time frames

Humana Healthy Horizons will make determinations for:

- Standard outpatient service prior authorization requests within 2 business days of obtaining appropriate medical information not to exceed 7 calendar days of receipt of request for prior authorization
- Standard inpatient hospital service prior authorization requests within 2 calendar days of obtaining appropriate medical information
- Concurrent inpatient authorization requests within 1 calendar day of obtaining appropriate medical information
- Standard CPST, FFT, ACT, homebuilders, MST and PSR authorization requests within 5 calendar days of obtaining appropriate medical information
- Crisis response service authorization requests within 1 calendar day of obtaining appropriate medical information
- Expedited authorization requests within 72 hours of receipt of the request for authorization
- Retrospective review requests within 30 calendar days of receipt of medical information, not to exceed 180 calendar days of receipt of request for authorization

All standard service authorization determinations will be made no later than 7 calendar days following receipt of the request for service:

- The service authorization determination may be extended up to an additional 14 calendar days if the member or 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 best interest.

Expedited service authorizations

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

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

Post-authorization

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

Humana Healthy Horizons 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 examples of services that are provided as benefits to the member but 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
- Inpatient rehabilitative services
- Long-term acute care
- Organ/tissue/bone transplants
- Select durable medical equipment, regardless of amount, specifically:
  - All powered or customized wheelchairs
  - Wheelchair rentals longer than 3 months
  - All miscellaneous codes (e.g., E1399)
  - Hearing aids
- Noncovered service and/or services beyond benefit limits for members younger than 21 that are deemed medically necessary or fall within the scope of EPSDT services

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

Note: The above website link routes to Humana Healthy Horizons' 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 healthcare provider is required to obtain advance approval from Humana Healthy Horizons 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. These services include but are not limited to:

- Emergency and post-stabilization services
- Nonemergent newborn deliveries
- Continuation of medically necessary services for members transitioning from other MCOs
- Crisis stabilization
- EPSDT screening and other appropriate immunizations/vaccinations based on the Periodicity Schedule
  - EPSDT preventative screening based on the American Academy of Pediatrics (AAP)/Bright Futures "Recommendations for Preventive Pediatric Health Care" schedule
  - Immunizations/vaccinations based on "Child and Adolescent Immunization Schedule" recommended by ACIP, AAP and the American Academy of Family Physicians
- 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.

Prior authorization during a state of emergency

During a state of emergency declared by the governor, LDH may suspend Utilization Management requirements, including prior authorization and concurrent review requirements, to ensure uninterrupted access to medically necessary healthcare services. The Utilization Management requirement suspensions only apply to members whose residential address on record is within the designated emergency area.

Providers will be reimbursed for medically necessary drugs, services, equipment, supplies and therapies provided to members during the state of emergency without requiring prior authorization. Out-of-state providers will be reimbursed for providing essential medical care to members who evacuated out of state, voluntarily or involuntarily, without requiring prior authorization.

Medical and behavioral health services

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

- Visit the provider portal at **Availity Essentials**.

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

When requesting authorization, please provide the following information:

- Member/patient name and Humana Healthy Horizons ID number
- Provider name
- NPI and 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 nonparticipating provider, if applicable
- Clinical information to support the medical necessity of the service
- Admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs for in-patient admission for elective, urgent or emergency care
- Date of surgery, name of surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs for inpatient planned surgery
- Date of surgery, name of surgeon and facility, diagnosis, procedure planned and anticipated follow-up needs after discharge for outpatient surgery

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

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

Retrospective review

Prior authorization is required to ensure certain services provided to our members are medically necessary and appropriately provided. At the provider's request, Humana Healthy Horizons will conduct a retrospective review to determine whether an authorization will be granted for services rendered prior to an authorization being requested.

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

Continuity of care

Members with special healthcare needs

If, at the time of enrollment, a new member is actively receiving medically necessary covered services from the previous MCO, Humana Healthy Horizons 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 less. Humana Healthy Horizons 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 nonparticipating provider.

Pregnant women

When a pregnant new member is receiving covered, medically necessary services from a previous MCO in addition to, or other than, prenatal services, Humana Healthy Horizons will temporarily cover the costs of continuation of such medically necessary services. After 30 days, Humana Healthy Horizons 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 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 will cover the costs of continued medically necessary prenatal care, delivery and postnatal care services without any form of prior authorization and regardless of the provider's contract status until Humana Healthy Horizons can safely transfer the member to a network provider without impeding service delivery.

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

If you have additional questions regarding Humana Healthy Horizons' continuity of care process and authorizations for new members, please call us at **1-800-448-3810 (TTY: 711)**.

Louisiana Medicaid Electronic Health Record (EHR) Incentive Payment Program

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

The purpose of the program is to improve outcomes, facilitate access, simplify care and reduce healthcare costs 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 HIEs and the Nationwide Health Information Network.

Details about this program and registration instructions can be found at **Louisiana Medicaid EHR Incentive Payment Program**.

Additional emergency department HIE requirements

Network emergency departments are required to exchange admission, discharge and transfer (ADT) data with an HIE emergency department visit registry to aid in identification and creation of policies around high utilizers, drug-seeking behavior and care management. The visit registry must consist of 3 basic attributes:

- The ability to capture and match patients based on demographics information
- The ability to identify the facility at which care is being sought
- At minimum, the chief complaint of the visit

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

Chapter 6: Claims and encounter submission, protocols and standards

Medical claims and behavioral health encounters

Healthcare providers should submit claims for all covered services for Humana Healthy Horizons members to Humana.

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

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

When filing an electronic claim, use one of the following payer IDs:

- 61101 for fee-for-service claims
- 61102 for encounter claims

Here are commonly used claims clearinghouses and their phone numbers:

Availity Essentials	**1-800-282-4548**
Waystar	**1-877-494-7633**
Trizetto	**1-800-969-3666**
Optum	**1-800-792-5256**
SSI Group	**1-800-880-3032**

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

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

LDH requires that all service encounters be submitted, including:

- Services paid at $0
- Fee-for-service and capitated provider encounters that require provider registration and documentation

Submission of provider service claims that identify members:

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

Sanctions for noncompliance can include liquidated damages and enrollment freezes.

Humana Healthy Horizons will issue payments for covered services provided to Medicaid members within 30 calendar days (or less, provided all required claim documentation is submitted and the contracted parties agree to another time frame that's in accordance with payment rates outlined in Exhibit A of the provider agreement).

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

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

For claim payment inquiries or complaints, please contact Humana Healthy Horizons Customer Care at **1-800-448-3810 (TTY: 711)** or your provider contracting representative. You also may visit **Availity Essentials** to review claim status and details. Submit claim disputes to:

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

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

Common submission errors and how to avoid them

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

- Patient not found
- Insured subscriber not found
- Patient date of birth on the claim does not match that found in our database
- Missing or incorrect information
  - Incorrect NPI/ZIP code/taxonomy
  - Missing NPI/ZIP code/taxonomy
  - Encounters with $0 value

- Invalid HCPCS code
- No authorization found

How to avoid these errors:

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

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

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

Clean claim submission

CMS developed claim forms that record the information needed to process and generate provider reimbursement. A clean claim is complete, legible, accurate, does not require investigation prior to adjudication and can be processed without additional provider information.

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

Clean claim criteria

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

A clean claim must:

- Comply with all standard coding guidelines
- Contain no missing information
- Be free of any defect or incorrect or obsolete coding or medical necessity

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

A clean claim is one that does not contain a defect or require Humana Healthy Horizons to investigate or develop prior to adjudication and can be processed without obtaining additional provider

information. The provider submits a clean claim by providing the required data elements on the standard claim forms along with any attachments and additional information. The required elements of a clean claim must be complete, legible and accurate. Clean claims must be filed within the appropriate time frame.

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

Individual providers who order, prescribe and/or refer (OPR) Medicaid services must be documented on claims. The only exceptions are nursing evaluations and preventive screenings. To fulfill claims processing requirements, the local education agency's (LEA) must input the ordering provider's name, Type 1 (individual) NPI and DK2 qualifier on all claims.

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

Abortion claim requirements

For induced abortions to be covered, 1 of the following 2 requirements must be met:

- A provider has found and certifies that on the basis of the provider's professional judgement, the life of the pregnant woman would be endangered if the fetus was carried to term. The certification statement must include the name and address of the member and be included on the claim form. The claim form must include the diagnosis or medical condition that makes the pregnancy life endangering.
- If a pregnancy is due to rape or incest:
  - A report of the act to law enforcement or treating provider's statement advising that the victim was physically or psychologically incapacitated and did not report the rape or incest must be submitted along with the treating provider's claim for reimbursement for performing an abortion.
  - The member must certify that the pregnancy is a result of rape or incest and the certification must be witnessed by the treating provider.
  - The Office of Public Health Certification of Informed Consent-Abortion form is signed and witnessed by the treating provider.

In order for Medicaid reimbursement to be made for an induced abortion, providers must attach a copy of the Office of Public Health Certification of Informed Consent-Abortion form to the claim form. The form is available from the Louisiana Office of Public Health by completing the following **Pregnancy Info Materials Request Form** or by calling **1-504-568-5330**.

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

CMS-1500 billing instructions

Medicaid requires all professional service and independent laboratory providers to include a valid CLIA number on all claims submitted for laboratory services, including CLIA waived tests. This information must be entered into box 23 of the CMS-1500 claim form. The CLIA number entered must contain the X4 qualifier and the CLIA certification number. The CLIA certification number includes the 2-digit state code, followed by the letter "D" and the provider's unique CLIA number. For further instructions on how to fill out the CMS-1500 claim form, please visit **CMS 1500 billing instructions**.

UB-04 form instructions

The CLIA number is not required for UB-04 claims. For instructions on how to fill out the UB-04 claim form, please visit **UB 04 billing instructions**.

Claim processing time frames

Per our agreement with LDH, Humana Healthy Horizons' processing responsibilities include:

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

Providers should expect payment at least once a week. To receive prompt payments, providers should sign up to submit and receive payments electronically. Providers will be notified when system updates will take place. Claims denied inappropriately due to system updates will be recycled within 15 calendar days of the system update.

Timely filing

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

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

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

* HEDIS is a registered trademark of the NCQA.

Claim overpayments

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

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

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

Suspension of provider payment

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 CFR 455.23. LDH may determine payments to the provider should not be suspended pending the investigation.

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

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

Electronic claim payments offer several advantages over traditional paper checks:

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

With EFT, your Humana Healthy Horizons claim payments are deposited directly in the bank account(s) of your choice. You also will be enrolled for our 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 EFT/ERA

Humana Healthy Horizons' provider portal features an ERA/EFT enrollment tool. To access the tool:

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

EFT payment transactions are reported with file format CCD+, an 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. Humana Healthy Horizons delivers 5010 835 versions of all ERA remittance files that are compliant with HIPAA. Humana Healthy Horizons uses the provider portal as the central gateway for delivery of 835 transactions. You can access your ERA through your claim's clearinghouse or through the secure provider tools available at **Availity Essentials**.

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

Multipayer 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 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 Essentials** for answers to any questions.

Incentive plans

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

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

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

Claim status

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

EOPs are current claim status statements Humana Healthy Horizons sends to providers. EOPs are generated weekly; however, the frequency with which providers receive EOPs depends on claim activity. Providers who receive EFT payments will receive an ERA and can access a “human readable” version at **Availity Essentials**.

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 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' 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 provides notification of upcoming code editing changes. We publish new code editing rules and our rationale for these changes on the first Friday of each month at **Humana.com/Edits**.

Coding and payment policies

Humana Healthy Horizons 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 sets.

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

To determine unit prices for a specific code or service, please visit **LDH Fee Index**.

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

The result of Humana Healthy Horizons' claim processing procedures are dependent on the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claim 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:
  - 2 or more surgeries performed the same day
  - 2 or more endoscopic procedures performed the same day
  - 2 or more therapy services performed the same day
- Whether a co-surgeon, assistant surgeon, surgical assistant or any other provider who is billing independently is involved
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under one billing code

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

- LDH regulations, manuals and other related guidance
- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee guidance, including the UB-04 Data Specifications Manual
- American Medical Association's (AMA) CPT and associated AMA publications and services
- HCPCS and associated CMS publications and services
- ICD-10
- American Hospital Association's 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
- 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 to modify current or adopt new claims processing procedures.

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

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

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

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

Coordination of benefits (COB)

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

While we try to maintain accurate information at all times, we rely on numerous sources for information updated periodically, and some updates may not always be fully reflected on Availity Essentials. Humana Healthy Horizons applies normal lesser of logic for processing COB claims. Payment is based on the lesser of the following calculations: allowed amount minus other insurance paid amount or member responsibility on the EOB, whichever is less.

Exceptions:

- Louisiana Health Insurance Premium Payment members: Humana Healthy Horizons will pay full member responsibility from the other insurance (OI) when processing secondary insurance.
- RHCs/FQHCs/American Indian clinics are reimbursed, making the provider whole, based on the Prospective Payment System (PPS) rate.

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

You can search for COB information on Availity Essentials by:

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

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

If you are aware of third-party liability (TPL) for a member, contact Louisiana Medicaid's TPL contractor, Gainwell, at **1-225-342-8662**. If the request to update TPL is urgent, such as if it is impacting access to care for the member, the provider can contact Humana Healthy Horizons directly. We will verify the request and update our system within 4 business hours of receiving an urgent TPL request.

Crossover claims

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

Medicaid program rules generally require members to exhaust other insurance coverage, including group health, workers' compensation and no-fault medical payment coverage before claims are submitted to the Medicaid program. Humana Healthy Horizons will coordinate benefits and process as secondary whenever these other forms of coverage are available. When a provider is aware of other coverage, claims should be submitted to the primary payer for a payment determination before claims are submitted to Humana Healthy Horizons. Claims involving COB will not be processed until an EOB/EOP or EDI payment information file is received, indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (i.e., $0 balance) still must be submitted to Humana Healthy Horizons for processing due to regulatory requirements. Humana Healthy Horizons 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 for the same items or services, this is considered an overpayment. Humana Healthy Horizons will provide 60 days' written notice, or 90 days if a 30-day extension was requested, to the provider before an adjustment for overpayment is made. If a dispute is not received from the provider,

adjustments to the overpayment will be made on a subsequent reimbursement. Providers also can issue refund checks to Humana Healthy Horizons for overpayments and mail them to the following address:

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

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

Recouping payments

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

When Humana Healthy Horizons recoups payment from a provider, the provider can either remit the amount to Humana Healthy Horizons or permit Humana Healthy Horizons 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 members for medically necessary covered services, except to collect member cost share, if applicable, and under very limited circumstances. Providers who knowingly and willfully bill a member for a Medicaid-covered service shall be guilty of a felony and, upon conviction, shall be fined, imprisoned or both, as defined in the Social Security Act of 1935.

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

Please remember that government regulations stipulate providers must hold members harmless in the event that Humana Healthy Horizons does not pay for a covered service performed by the provider. Members cannot be billed for services that are administratively denied. The only exception is if a Humana Healthy Horizons 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 the member's financial responsibility. The form or type of agreement must specifically state the services or procedures that are not covered by Medicaid.

Please call Humana Healthy Horizons provider services at **1-800-448-3810 (TTY: 711)** for guidance before billing members for services.

Missed appointments

In compliance with federal and state requirements, Humana Healthy Horizons members cannot be billed for missed appointments. Humana Healthy Horizons 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 **1-844-613-1638 (TTY: 1-800-618-4781)**. MediTrans provides emergency transportation, as well as nonemergency ambulance transportation, to and from medical appointments when no other means of transportation is available and the member's condition is such that use of any other method of transportation is contraindicated or would make the member susceptible to injury.

If you are concerned about a Humana Healthy Horizons member who misses appointments, please call member services at **1-800-448-3810 (TTY: 711)** to refer member to our Case Management Program.

Member termination claim processing

From Humana Healthy Horizons to another plan:

If a member leaves Humana Healthy Horizons' plan and enrolls in a different Medicaid plan, Humana Healthy Horizons 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 LDH, Humana Healthy Horizons will identify which members received a retro-eligibility date and require termination of enrollment within the Humana Healthy Horizons claims payment system.
2. Humana Healthy Horizons will initiate the member termination process. This will be completed within 5 business days of receipt of the 834 file.
3. Humana Healthy Horizons will determine whether claims for rendered services were paid after the member's Humana Healthy Horizons Medicaid benefits ended. This process will be completed within 5 business days.
4. Humana Healthy Horizons will notify affected providers that recoupment of payment will occur for the claim(s) identified in the recoupment letter. The provider will have 60 calendar days to respond to the notice.
5. If the affected provider has not appealed the recoupment payment or submitted a refund check within 60 calendar days, Humana Healthy Horizons 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 5 business days of completion of payment adjustment(s).

7. After the recoupment has received a processed date stamp, a voided encounter for the affected claims will be submitted to LDH assuming the original submitted encounter was previously accepted. Please note that if the original encounter was denied or rejected by LDH, a void does not need to occur.
8. Upon successful completion of the encounter-void process, affected providers will be sent a courtesy letter informing them that the original payment was successfully cleared from the LDH system and that they can proceed to bill the claim(s) with the member's active Medicaid plan. This will happen within five business days. Please note that if the state did not accept the voided encounter, the process may be delayed an additional 10 business days.

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

From another plan to Humana Healthy Horizons in Louisiana:

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

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

Chapter 7: Reconsiderations, appeals and complaints

Claim reconsiderations

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

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

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

Online:

Provider claim reconsiderations about finalized claims may be submitted online via Availity Essentials.

To begin, sign in at **Availity Essentials**, and use the claim status tool to locate the claim and select the “Dispute Claim” button. Then go to the request in the Appeals worklist (located under “Claims & Payments”) to supply needed information and documentation and submit the request to Humana Healthy Horizons. Status and high-level Humana Healthy Horizons determination for claim disputes submitted online can be viewed in the Appeals worklist. For training opportunities, visit **Humana.com/ProviderWebinars**.

Phone:

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

Mail:

Providers can submit reconsiderations in writing at the following address:

Humana Healthy Horizons in Louisiana Provider Reconsiderations

P.O. Box 14601

Lexington, KY 40512-4601

Or via email to:

LAMedicaidProviderRelations@humana.com

Claim appeals

If a provider is dissatisfied with the claim reconsideration's determination, the provider may request a second-level review called a claim appeal. Providers may submit a written appeal within 90 calendar days from the date on the determination letter for claims reconsideration. Humana Healthy Horizons will review and provide a determination within 30 calendar days or any successor date that may be required.

Providers should follow the appeal process:

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

Providers can file an appeal in writing to:

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

Binding arbitration

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

Providers should review their contract with Humana Healthy Horizons for any specific language related to arbitration. Email binding arbitration requests to **HumanaHealthyHorizonsLouisiana@humana.com**.

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

Independent review

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

Subject to review by LDH, providers may aggregate multiple adverse determinations involving Humana Healthy Horizons when the specific reason for nonpayment of the claims aggregated involves a dispute regarding a common substantive question of fact or law. If a provider elects to aggregate its claims, the independent reviewer may, upon request, allow for up to an additional 30 days to provide relevant information related to the independent review requests.

Independent review is a 2-step process:

Step 1:

Submit a request for IRR to Humana Healthy Horizons within 180 calendar days from 1 of the following:

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

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

Step 2:

If Humana Healthy Horizons 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, the provider has 60 days from the date the IRR was submitted to Humana Healthy Horizons to request an independent review from LDH.

Providers can expect the following after requesting an independent review:

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

concerning an independent reviewer's decision that is not brought within 60 days of the decision shall be barred indefinitely.

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

IRR forms:
Humana: **Independent review request form—Humana**
LDH: **Independent review request form—LDH**

Provider issue escalation and resolution

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

Providers may file a complaint about:

- Benefits and limitations
- Eligibility and enrollment of a member or care provider
- Member issues or Humana Healthy Horizons plan issues
- Availability of health services from Humana Healthy Horizons to a member
- Delivery of health services
- Quality of service

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

Phone:

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

Mail:

Providers can submit a complaint in writing using the following address:

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

In person: Contact your Provider Relations representative to file in person.

Email: LAMedicaidProviderRelations@humana.com

Louisiana Department of Health dispute process

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

Member grievance and appeal system process

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

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

Filing a grievance or appeal

If members have questions or issues, they can call **1-800-448-3810 (TTY: 711)**, Monday through Friday, 7 a.m. to 7 p.m. If dissatisfied with the answers from Customer Care, the member can file a grievance or appeal.

Members can call Customer Care to file a grievance or 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 Care. If a member requests a form from Humana Healthy Horizons, it will be mailed within 3 working days. When filling out the form, the member can request help from Humana Healthy Horizons 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 member ID number
- Facts and details of actions taken to correct the issue
- What action would resolve the grievance or appeal
- Member's signature
- Date

Grievance review timelines

The member has the right to file a written or verbal grievance. The grievance process may take up to 90 calendar days; however, Humana Healthy Horizons will resolve the member's grievance as quickly as the health condition requires. A letter explaining the outcome of the grievance will be sent within 90 calendar days of the date Humana Healthy Horizons 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 representative (AOR) required?	Yes
Is an acknowledgment of the grievance required?	Yes, within 5 business days of receipt
What is the resolution time frame?	No later than 90 calendar days after receipt

Appeal review timelines

A member must file the appeal either verbally or in writing within 60 calendar days of the date on the notice of adverse action. The date of the oral appeal request will be considered the date of receipt. Humana Healthy Horizons will resolve the appeal as quickly as the health condition requires. A letter telling the member the outcome of the appeal will be sent within 30 calendar days of the date Humana Healthy Horizons receives the request. The member has the right to review the member's case before and during the appeal process.

Louisiana Medicaid appeal first-level review

Topic	Response
In what manner may the appeal be submitted?	Oral or written If oral, the date of request is considered the date of receipt
What is the time frame to submit the appeal?	Within 60 calendar days from the date on the notice of adverse action
Is an AOR required?	Yes
Is an acknowledgment of the appeal required?	Yes, within 5 business days receipt of the appeal
What is the decision notification method?	Written
What is the decision time frame?	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 jeopardize the member's life, health or ability to attain, maintain or regain maximum function. The member or the member's legal representative can file an urgent or expedited appeal. These appeals are resolved within 72 hours. When making an appeal, the member or representative needs to inform Humana Healthy Horizons that this is an urgent or expedited appeal. An expedited appeal may be made by calling **1-800-448-3810 (TTY: 711)**. If it is determined that an expedited process is not required, the appeal will go through the normal process.

Note: Humana Healthy Horizons does not discriminate 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 AOR required?	Yes
What is the decision notification method?	Oral notification followed by written notification
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 Healthy Horizons' appeal decision, the member 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 LDH.

A member may seek a state fair hearing after exhausting Humana Healthy Horizons' appeal process. A member who has exhausted Humana Healthy Horizons' appeal process may file a request for a state fair hearing within 120 calendar days of the date on Humana Healthy Horizons' notice of resolution.

A state fair hearing request can be filed:

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

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

Online: **Louisiana Division of Administrative Law**

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 sends a notice of appeal resolution that is not fully in the member's favor.

Chapter 8: Quality and compliance

Quality improvement

Humana Healthy Horizons 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' quality improvement program and its progress toward goals, call **1-800-448-3810 (TTY: 711)**.

Participating providers agree to assist Humana Healthy Horizons in Louisiana with its performance in the following quality management functions:

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

HEDIS—a set of performance measures. Humana Healthy Horizons may conduct medical record reviews to identify gaps in care for Humana Healthy Horizons 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 2 primary routes for supplemental data: nonstandard and standard.

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

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

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

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

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

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

Initiate performance improvement projects (PIPs)—projects 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 Healthy Horizons' lasting commitment to make a difference. Humana Healthy Horizons uses HEDIS as one measure of the quality of care delivered to Humana Healthy Horizons members.

The NCQA accredits and certifies a wide range of healthcare organizations and manages the evolution of HEDIS, the performance measurement tool used by more than 90% of the nation's health plans. HEDIS scores are compiled using claims and medical records. Humana Healthy Horizons 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 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 MCOs and focus on preventive care, health screenings and prenatal care, as well as special populations.

Quality Assessment and Performance Improvement (QAPI) program

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

- Performance improvement projects
- Overutilization and underutilization 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 PCPs
- Assessment of quality and appropriateness of care furnished to children with special healthcare needs
- Continuity and coordination of care
- HEDIS measurement
- 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 EQRO to conduct medical record reviews for Humana Healthy Horizons members.

Health record review

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

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

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

Humana Healthy Horizons will ensure medical records include 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
    - Provider initials must be identified with correlating signatures

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

We appreciate your attention to detail in chart documentation.

Value-based payment (VBP) programs

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

To learn more about Humana Healthy Horizons' VBP programs, including whether you qualify, and other quality programs available through Humana Healthy Horizons, please contact your Provider Relations representative or Provider Engagement associate.

Compliance and ethics

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

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

- Formalizes Humana Healthy Horizons' 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 noncompliance with laws and regulations; Humana Healthy Horizons policy; professional, ethical or legal standards; and fraud, waste and abuse concerns
- Allows Humana Healthy Horizons to resolve problems promptly and minimize negative impact on our members or business that could include financial losses, civil damages, penalties and sanctions

General compliance and ethics expectations for providers include:

- Adhering to professional ethics and business standards
- Notifying Humana Healthy Horizons 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 provider services at **1-800-448-3810 (TTY: 711)**.

Fraud, waste and abuse policy

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

Humana Healthy Horizons 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 their member ID card to obtain services or supplies from Humana Healthy Horizons 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 the member's enrollment form that materially affects the member's plan eligibility

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

In addition, providers may use the following contacts:

Telephonic:

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

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

Web: **Ethics Help Line** or **Humana**

Chapter 9: Specialized behavioral health

Objectives of the behavioral health program

Humana Healthy Horizons takes a holistic, multifaceted approach to member care, with the understanding that behavioral health issues can have a negative impact on an individual's social factors and physical health, which can interfere with a person's 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 providers have access to training resources and evidence-based practice guidelines to facilitate collaboration and allow seamless coordination and continuity of member care.

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

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

Goals of the behavioral health program

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

Our integrated care management program is based on the philosophy of continuously improving the member's experience and quality of care, improving population outcomes and decreasing overall healthcare costs. Humana Healthy Horizons' Utilization Management, care management and population health programs are integrated in our Model of Care. We work closely with the providers in our Humana Healthy Horizons network to ensure these goals are met in a seamless manner, with

our members receiving the full support of their various providers and the Humana Healthy Horizons support system.

Integration of behavioral health and medical care

Humana Healthy Horizons provides a comprehensive integrated care management model for our members at highest risk, including those with specialized behavioral health needs. Utilizing nurses and behavioral health licensed clinicians, including social workers and counselors, this multidisciplinary 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 multidisciplinary 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, 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 on member needs and preferences. Your patient's care plan is viewable by accessing the care coordination portal via **Availity Essentials** or requesting a copy by calling us at **1-800-448-3810 (TTY: 711)**.

Provider coordination for behavioral health

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

Primary care providers are required to:

- Provide basic behavioral health services to members, including:
  - Screening for mental health and substance use issues during routine and emergent visits
  - Prevention
  - Early intervention
  - Medication management
  - Treatment and referral to specialized behavioral health services
- Follow up with behavioral health providers to coordinate integrated and unduplicated care
- Obtain the necessary signed release for sharing PHI, including compliance with 42 CFR Part 2 requirements around SUD

Behavioral health providers are required to:

- Notify the PCP when a member initiates behavioral health services with the provider

- Obtain a signed release for sharing PHI, in compliance with 42 CFR Part 2 requirements around SUD, before sharing information with the PCP
- Provide initial and quarterly summary reports to the PCP (after receiving the aforementioned 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 is committed to coordinating with third-party member resources and will invite third-party care managers to join a member's MDT, as appropriate and upon member request.

Continuity of care for behavioral health

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

Addiction

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

Addiction is characterized by:

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

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

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

Successful prevention and treatment outcomes for addiction are similar to those for chronic medical diseases. 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.[2] There are 4 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 addiction manage their conditions successfully. Hope— the belief that these challenges and conditions can be overcome—is the foundation of healing. Recovery is characterized by continual growth and improvement in one's health and wellness that may involve delays. Because setbacks are a natural part of life, resilience also is important. Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress. Learning to bounce back can offer members the opportunity to improve their lives by maximizing potential and success.

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

Recovery services and supports must be flexible. Supporting recovery requires that addiction services:

- Be responsive and respectful to the health beliefs, practices and cultural and linguistic needs of diverse people and groups
- Actively address diversity in the delivery of services
- Seek to reduce health disparities in access and outcomes

Treatment

There are many treatment options that have been successful in treating addiction, including:

- Behavioral counseling
- Medication
- Evaluation and treatment for co-occurring mental health issues such as depression and anxiety

Disclosures

Adherence to patient confidentiality laws is required of every Humana Healthy Horizons 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, HIPAA requires that providers only release 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 use treatments almost exclusively prevents disclosures without the patient's consent.

Visit the following for more information about HIPAA and 42 CFR Part 2:

- HIPAA: **Centers for Medicare & Medicaid Services: HIPAA and administrative simplification**
- 42 CFR Part 2: **SAMHSA: Substance use confidentiality regulations**

Provider expectations regarding Office of Juvenile Justice and DCFS coordination

Coordinated system of care (CSoC)

The CSoC is designed to provide services and support 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 LDH, the Department of Education, DCFS and the Office of Juvenile Justice. Humana Healthy Horizons 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.
- The child has attempted self-harm or tried to hurt someone else.

- The child is getting suspended and/or expelled from school.
- The 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 **1-800-448-3810 (TTY: 711)**.

Payment for services provided to CSoC recipients

CSoC-eligible members receive physical health, pharmacy, and the following behavioral health services from Humana Healthy Horizons: Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), and Substance Use Disorder (SUD) Residential services (ASAM Levels 3.1, 3.2-WM, 3.3, 3.5, 3.7 and 3.7-WM). All other behavioral health and CSoC services are covered by Humana. Humana Healthy Horizons is responsible for payment to enrolled providers for the provision of specialized behavioral health services for any month in which the recipient has active CSoC eligiblity with a begin date later than the first day of that month. Humana Healthy Horizons is responsible for payment of PRTFs, TGHs and SUD residential services (ASAM levels 3.1, 3.2-WM, 3.3, 3.5 3.7 and 3.7-WM). Providers should submit service claims for these recipients to Humana Healthy Horizons until the end of the month.

Act 503

Act 503 revises the components of CPST and PSR and the staff able to provide these services. Per Act 503:

- "Community psychiatric support and treatment services" means CMS-approved Medicaid mental health rehabilitation services designed to reduce disability from mental illness, restore functional skills of daily living, build natural supports, and achieve identified person-centered goals or objectives through counseling, clinical psycho- education, and ongoing monitoring needs as set forth in an individualized treatment plan.
- "Psychosocial rehabilitation services" means CMS-approved Medicaid mental health rehabilitation services designed to assist the individual with compensating for or eliminating functional deficits and interpersonal or environmental barriers associated with mental illness through skill building and supportive interventions to restore and rehabilitate social and interpersonal skills and daily living skills.
- Any individual rendering the assessment and treatment planning components of CPST and PSR services for a licensed and accredited provider agency shall be a fully licensed mental health professional.
- Any individual rendering any of the other components of CPST services for a licensed and accredited provider agency shall be a fully licensed mental health professional, a provisionally licensed professional counselor, a provisionally licensed marriage and family therapist, a licensed master social worker, a certified social worker or a psychology intern from an APA-approved internship program.

- Any individual rendering PSR services for a licensed and accredited provider agency shall hold a minimum of one of the following: a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, criminal justice or human growth and development or have a bachelor's degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology; or be 21 years of age or older as of January 1, 2022, have a high school diploma or equivalency, and have been continuously employed by a licensed and accredited agency providing PSR services since prior to January 1, 2019.

Individuals providing services

Services must be provided in accordance with the requirements of the LDH Behavioral Health Services Manual (BHSM). The BHSM describes the practice requirements and can be found at the following link: **BHS_Provider_Manual.pdf**. Humana Healthy Horizons will periodically inform providers of updates to the BHSM through provider website and Availity notifications.

Provider quality monitoring program for specialized behavioral health providers

Humana Healthy Horizons monitors specialized behavioral health providers and facilities across all levels of care, incorporating desktop and onsite audits and member interviews with a focus on unlicensed providers delivering care. Humana Healthy Horizons conducts quality reviews using a sample of providers' client records on a quarterly basis. Providers are required to adhere to minimum provider qualifications and requirements at the organizational level and the individual staff level as established by Louisiana law, rules, regulations, state plan, waivers, the Louisiana Medicaid Behavioral Health Services Provider Manual and other governing bodies. This includes, but is not limited to, requirements associated with licensure, accreditation, educational and professional experience, and training inclusive of utilization of LDH-approved training curriculum in the delivery of services, if applicable, as established by the Louisiana Medicaid Behavioral Health Services Provider Manual. Provider quality monitoring verification includes a review of behavioral health treatment records. The Provider Quality Monitoring Review criteria will include the following, but is not limited to:

- adherence to clinical practice guidelines
- adherence to agency specific clinical documentation requirements
- enrollee rights and confidentiality, including advance directives and informed consents
- cultural competency and patient safety including adverse incident management/reporting
- appropriate use of restraints and seclusions
- treatment planning components (evaluates if the assessment and treatment are conducted timely and include member participation, the quality of the assessment and treatment plan, whether members are receiving services as reflected in the treatment/service plan)
- adequate discharge planning, as applicable and care coordination

Humana Healthy Horizons initiates the appropriate corrective action when a provider or staff member fails to meet quality standards and requirements, minimum provider qualifications or requirements, or appointment availability standards, or is found to be out of compliance with contract provisions, federal and state regulations, laws, rules, the state plan amendment (SPA), waivers, the Louisiana Medicaid Behavioral Health Services Provider Manual or the managed care manual. Humana Healthy Horizons monitors and evaluates corrective actions taken to ensure appropriate changes have been made in a timely manner.

Providers are expected to meet performance requirements and ensure member treatment is efficient and effective. Providers are expected to monitor and evaluate their own compliance with performance requirements to assure delivery of quality care.

Providers should:

- Cooperate with medical record reviews and reviews of telephone and appointment accessibility
- Cooperate with our complaint review process
- Participate in provider satisfaction surveys
- Cooperate with reviews of quality-of-care issues and critical incident reporting

In addition, providers are invited to participate in our quality improvement committees and in local focus groups.

Applied behavioral analysis (ABA) quality monitoring review

Humana Healthy Horizons monitors specialized ABA providers and facilities across all levels of care, which incorporates onsite and desktop reviews. Providers are required to adhere to minimum provider qualifications and requirements at the organizational level and the individual staff level as established by Louisiana law, rules, regulations, the SPA, waivers, the Louisiana Medicaid Behavioral Health Services Provider Manual and other governing bodies. ABA Provider quality monitoring verification includes a review of ABA treatment records.

Humana Healthy Horizons' review criteria shall address the following areas, at a minimum:

- Quality of care consistent with professionally recognized standards of practice
- General record elements
- Member rights and confidentiality
- Comprehensive diagnostic evaluation
- Prescription/referral for ABA therapy
- Record of qualifying diagnosis
- Treatment plan
- Progress notes
- Continuity and coordination of care
- Patient safety

- Cultural competency
- Adverse incidents
- Discharge planning

Provider network monitoring

Humana Healthy Horizons provider network review monitors specialized behavioral health providers and facilities across all levels of care, incorporating desktop and onsite audits. Humana Healthy Horizons conducts provider network monitoring reviews using a sample of provider and staff personnel records and other administrative records on a quarterly basis. Providers are required to adhere to minimum provider qualifications and requirements at the organizational level and the individual staff level as established by Louisiana law, rules, regulations, the SPA, waivers, the Louisiana Medicaid Behavioral Health Services Provider Manual and other governing bodies. This includes, but is not limited to, requirements associated with licensure, accreditation, educational and professional experience, and training inclusive of utilization of LDH-approved training curriculum in the delivery of services, if applicable, as established by the Louisiana Medicaid Behavioral Health Services Provider Manual.

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

Humana Healthy Horizons monitors and evaluates corrective actions taken to ensure appropriate changes have been made in a timely manner. Providers are expected to meet performance requirements and ensure member treatment is efficient and effective. Providers are expected to monitor and evaluate their own compliance with performance requirements to assure delivery of quality care. Providers must meet licensure and/or certification requirements, as well as other additional requirements, as outlined in the Louisiana Medicaid Behavioral Health Services Provider Manual, determined by their level of care.

Behavioral Health Fidelity Monitoring Plan for evidence-based programs

Evidence-based practice (EBP) models contain a combination of clinical expertise, patient values and evidence research. Fidelity monitoring is an evaluation of the program design and the accurate delivery of intended consistent program interventions. EBP programs operating with high fidelity produce positive consumer outcomes.

Ongoing fidelity monitoring allows Humana Healthy Horizons to attribute consumer outcomes to interventions. Humana Healthy Horizons' Behavioral Health Fidelity Monitoring Plan monitors the following:

- ACT
- EMDR
- FFT
- FFT-CW
- Homebuilders
- MST
- IPS
- CPP
- PCIT
- PPT and YPT
- Tripe P Positive Parenting Program
- Trauma-focused cognitive behavioral therapy (TF-CBT)
- Other programs as identified by LDH

The Fidelity Monitoring Plan assesses for program readiness; establishes a baseline status for new providers and program implementation; creates an action plan; provides provider consultation and training, as needed; and continually monitors program-level implementation/processes and participant interventions. Fidelity monitoring is completed by vendors that represent the interests of Humana Healthy Horizons.

Chapter 10: Member enrollment and eligibility

Medicaid eligibility

Medicaid eligibility is determined by the LDH in the member's county of residence.

LDH provides eligibility information to Humana Healthy Horizons daily via an 834 file for members assigned to Humana Healthy Horizons. Eligibility begins on the first day of each calendar month for members joining Humana Healthy Horizons, except for babies born to an eligible mother.

Newborn enrollment

Humana Healthy Horizons begins coverage of newborns on the date of birth, up to a minimum of 1 month, when the newborn's mother is a member of the Humana Healthy Horizons plan. The mother has the option of choosing another MCO for her baby, following the birth. If the mother chooses a different MCO for the baby, enrollment in the new MCO will be effective the first day of the month after she chooses the new MCO if the choice is made on or before the second to last working day of the month. The newborn will appear on the chosen PCP's member eligibility list after the

baby is added to the Humana Healthy Horizons system. If a PCP for the newborn is not chosen during the hospital stay, Humana Healthy Horizons provides a minimum of 14 calendar days for one to be chosen for the member before one is auto assigned.

You can verify eligibility for a newborn on the **Availity Essentials** provider portal.

Hospitals are required to report all births, within 24 hours of birth, via the LDH self-service provider portal. Hospitals also are required to register births through the Louisiana Electronic Event Registration System (LEERS), administered by LDH/ Vital Records Registry, within 15 calendar days of birth. Within 3 business days, LDH will assign the newborn a Medicaid ID and add the baby to the Medicaid eligibility file.

New member kits

Each new member household receives a new member kit (including a welcome letter) and an ID card for each person in the family who has joined Humana Healthy Horizons. New member kits are mailed separately from the member ID card.

The new member kit contains:

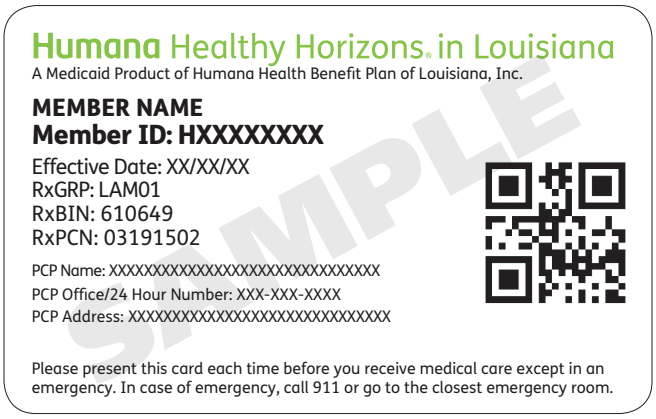
- A welcome letter

- Information on how to obtain a copy of the Humana Healthy Horizons provider directory
- A member newsletter, which explains how to access plan services and benefits, including the member handbook
- A health needs assessment survey
- Continuity of care form

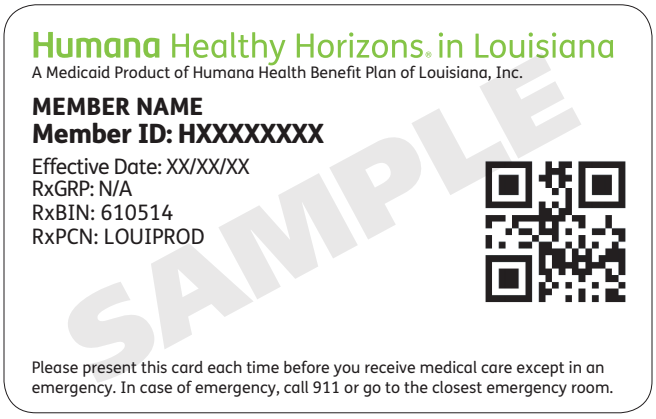
Member ID cards

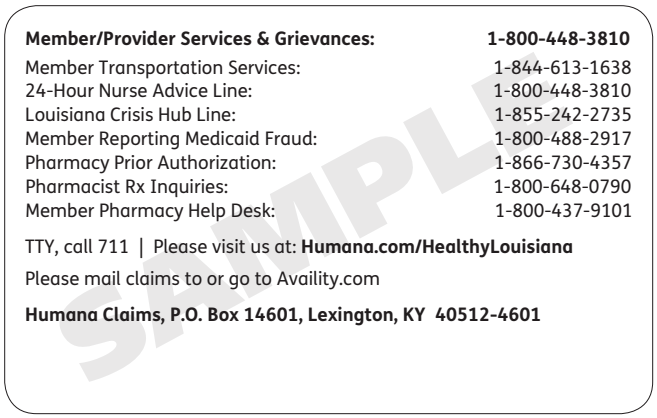
All new Humana Healthy Horizons members receive a member ID card. A new card is issued only when the information on the card changes or if a member loses a card or requests an additional card. Eligible members will receive a state Medicaid card and a Humana Healthy Horizons ID card; both must be presented at regular and follow-up provider appointments.

The member ID card is used to identify a Humana Healthy Horizons member; it does not guarantee eligibility or benefits coverage. Members may disenroll from Humana Healthy Horizons 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.

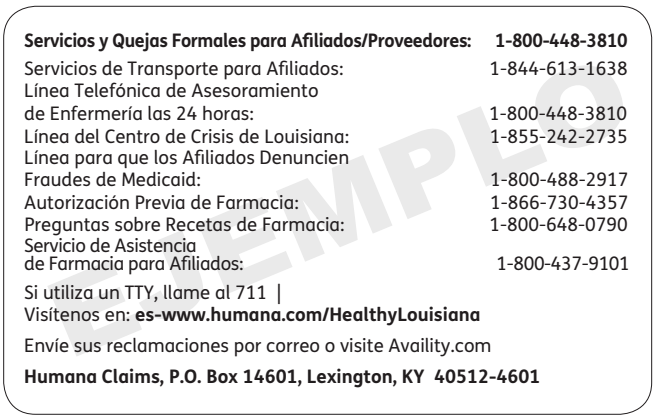


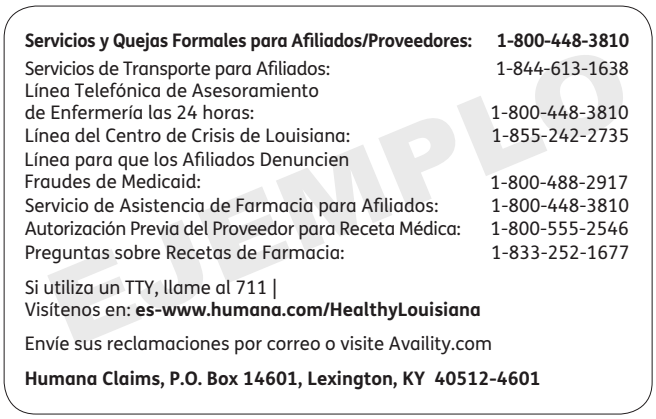
2025 Louisiana Medicaid English card





2025 Louisiana Medicaid behavioral health English card





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

Front:	Back:
Humana Healthy Horizons member ID: Use this number on claims	Behavioral Health Hotline: Members can call this hotline 24/7/365 for mental health or addiction services.
PCP name/phone: Members choose a participating provider to be their PCP. If no choice is made, Humana Healthy Horizons 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 checks and more.

Automatic 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 coverage. Humana Healthy Horizons' internal system can identify a member's previous PCPs within Humana Healthy Horizons' 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

PCP panel. Humana Healthy Horizons' internal editing system also ensures that the auto assigned PCP is age-appropriate for the member (i.e., pediatricians will be assigned to pediatric members and adults assigned to a PCP who specializes in the treatment of adults). Newborn members have up to 14 days for PCP assignment once received on the 834 enrollment file.

Monitoring PCP reassignment

Humana Healthy Horizons will conduct monthly analytical reviews of PCP membership assignments to ensure members are appropriately paneled. Humana Healthy Horizons provider panel reports (file name: REMBX) will be generated on the 15th of each month; panel reports and the results of the analytical output of our claims-based attribution model will be shared with the PCP via Availity Essentials. PCPs will be given 15 business days to dispute any member currently on their panel or the outcome of the claims-based attribution analysis with the market. The provider will submit a dispute form and supporting information to **LAPEAttributionDispute@humana.com**. Humana Healthy Horizons will review and the determination will be communicated to the provider within 15 calendar days of receipt of the dispute.

Disenrollment

Humana Healthy Horizons, LDH or the member can initiate disenrollment. Members may disenroll from Humana Healthy Horizons for a number of reasons, including:

- Voluntary disenrollment; members allowed to make up to 2 plan changes per calendar year
- Humana Healthy Horizons doesn't cover services requested by the member because of moral or religious objections
- Lack of access to Humana Healthy Horizons-covered services as determined by LDH

Humana Healthy Horizons can initiate member disenrollment for the following reasons:

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to provide services to the member or others

Please notify the Humana Healthy Horizons Care Management department at **1-800-448-3810 (TTY: 711)** if one or all of the situations listed above occur. Please see the section below for procedures for dismissing noncompliant members from your practice. We can counsel the member or, in severe cases, initiate a request to LDH for disenrollment. LDH will review each disenrollment request and determine if the request should be granted. LDH provides disenrollment information to Humana Healthy Horizons daily via the 834 file for members assigned to Humana Healthy Horizons. Disenrollment from Humana Healthy Horizons always will occur at the end of the effective month.

If members lose Medicaid eligibility, they also lose eligibility for Humana Healthy Horizons benefits.

Automatic renewal

If Humana members lose Medicaid eligibility but become eligible again within 60 days, they are automatically reenrolled in Humana Healthy Horizons and assigned to the same PCP, if possible. Please call provider services at **1-800-448-3810 (TTY: 711)** if you have questions about disenrollment reasons or procedures.

Referrals for release due to ethical reasons

Humana Healthy Horizons 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 CFR 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' provider network.

When providers feel that their conscience, religious beliefs or ethical principles require involuntary dismissal of a member as their patient, the provider's office must notify the member of the dismissal by certified letter.

The letter should include:

- The reasoning behind the dismissal request
- Referral to another provider licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition
  - The provider must be actively enrolled with the state of Louisiana to provide Medicaid services to beneficiaries and must be in Humana Healthy Horizons in Louisiana's provider network.
- Instructions to call Humana Healthy Horizons' member services at **1-800-448-3810 (TTY: 711)** for assistance in finding a preferred in-network provider.

A copy of the letter must be sent or faxed to Humana at the following address:

Mail:
Humana
Attn: Service Operations Resolution Team (SORT)
P.O. Box 221529
Louisville, KY 40252-1529

Fax: 937-226-6916

Member support services benefits

Humana Healthy Horizons offers a variety of educational services, benefits and support to our members to facilitate their use and understanding of our services, promote preventive healthcare and encourage appropriate use of those services. We are always happy to work with you to meet the healthcare needs of our members.

Member services

Humana Healthy Horizons can assist members who have questions or concerns about benefits and services such as case or disease management.

Representatives are available by telephone at **1-800-448-3810 (TTY: 711)**, Monday through Friday, 7 a.m. to 7 p.m., 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 7 days a week, 365 days a year, by calling **1-800-448-3810 (TTY: 711)**.

The nurses educate members about the benefits of preventive care.

Key features of this service include:

- Access to a Nurse available to answer health-related questions via telephone, systematic assessment of symptoms, and recommendations for the most appropriate treatment, clinical resources and care setting (e.g., home, virtual consultation, retail clinic, provider's office, urgent care facility, ER, etc.)
- Urgent and non-urgent care advice
- Health and wellness education, reminders and resources
- Condition, procedure and treatment explanations
- Medication information, including drug interactions, appropriate use, and adherence benefits and strategies

Emergency behavioral health services

For behavioral health services, members should call a contracted behavioral healthcare provider in their area. The provider can give the member a list of common behavioral problems and advise how to recognize any symptoms. For assistance in finding a provider, members may call Humana Healthy Horizons' member services at **1-800-448-3810 (TTY: 711)**, Monday through Friday, 7 a.m. to 7 p.m., 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 behavioral health crisis hotline

For emergency behavioral healthcare within or outside the service area, please instruct members to call their behavioral health service provider (who maintains the member's Crisis Mitigation Plan and provides 24-hour on-call telephone assistance to prevent relapse or harm to self or others, referral to other services, and support during crises) . They should contact you or The Louisiana Crisis Hub first if they are not sure the problem is an emergency. The Louisiana Crisis Hub is staffed by trained personnel 24 hours a day, 7 days a week, year-round. Crisis hotline staff includes qualified behavioral health services professionals who can assess, triage and address specific behavioral health emergencies at 24-hour Behavioral Health Crisis Line (24/7/365): 1-855-24CARE5 or 1- 855-242-2735. The Louisiana Crisis Response website is **https://www.louisianacrisisconnect.org/louisianacrisishub/en/home**.

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 11: Member rights and responsibilities

As a Humana Healthy Horizons provider, you are required to respect the rights of our members. Humana Healthy Horizons members are informed of their rights and responsibilities via the member handbook. A list of our member's rights and responsibilities is below.

All members are encouraged to take an active and participatory role in their own health and the health of their family. Each member is guaranteed the following rights:

- To receive information in accordance with federal regulations as described in the contract and department-issued guides
- To receive information about the organization, its services, its practitioners, provider and member rights and responsibilities
- To receive courteous, considerate and respectful treatment provided with due consideration for the member's dignity and privacy
- To have a candid discussion of appropriate or medically necessary treatment options and alternatives in a manner appropriate to member's condition and ability to understand, regardless of cost or benefit coverage
- To participate in treatment decisions, including the right to:
  - Refuse treatment
  - Have 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
  - Receive 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
- To be able to 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
- To 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

- To be furnished with healthcare services in federal regulations governing access standards
- To be able to 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.
- To be able to file a grievance to LDH or other appropriate licensing or certification agency as allowed in federal regulations regarding noncompliance with the advance directive requirements
- To be able to choose health professionals to the extent possible and appropriate under federal regulations
- To be able to request a practitioner of the same race, ethnicity and/or language if there is a practitioner available in the member's network
- To receive healthcare services in accordance with all other applicable federal regulations
- To exercise the rights described herein without any adverse effect on member treatment by LDH, the MCO or its contractors or providers
- To make recommendations to the member rights and responsibilities statement

Member responsibilities shall include, but are not limited to:

- Informing the MCO of the loss or theft of a member's MCO ID card
- Presenting the member ID card when using healthcare services
- Protecting the member ID card and understanding that misuse of the card, including loaning, selling or giving it to others, could result in loss of Medicaid eligibility and/or legal action
- Being familiar 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
- Providing the information Humana Healthy Horizons and your healthcare providers need in order to care for you
- Following the advice and instructions for care members agreed on with their doctors and other healthcare providers
- Understanding their health problems, participating in developing treatment goals and following the provider-prescribed treatment of care or explaining as soon as possible why the treatment cannot be followed
- Making every effort to keep all agreed-upon appointments and contacting the provider in advance if unable to do so
- Accessing preventive care services

- Notifying Humana Healthy Horizons immediately if the member has a workers' compensation claim, a pending personal injury or a medical malpractice lawsuit, or if the member is involved in an auto accident
- Reporting any changes in family size, living arrangements, parish of residence or mailing address to LDH at: Phone: **1-888-342-6207**, Monday through Friday, 7 a.m. to 4:30 p.m.

  Website: **LDH**

  Local offices: **LDH Medicaid directory**

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

In the day-to-day business of patient treatment, payment and healthcare operations, Humana Healthy Horizons and its providers routinely handle large amounts of 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 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 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

HIPAA privacy rules require 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.

LDH provides a privacy notice to Medicaid members. Access the HIPAA information page at **LDH HIPAA policies and forms**. The notice informs members of how 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 PHI for treatment, payment and healthcare operations.

Member consent to share health information

Obtaining a member's written permission to share patient information is defined as securing consent. Not all disclosures require the member's permission.

The following are consent requirements that pertain to sensitive health information (SHI) and SUD treatment:

- SHI is defined by the state (e.g., relating to HIV/AIDS, mental health, sexually transmitted diseases).
- SUD 42 CFR Part 2 pertains to federal requirements that apply to all states.

While all member data is protected under HIPAA privacy rules, Part 2 provides more stringent federal protections in an attempt to protect individuals with SUDs who could be subject to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protections for the sharing of certain information determined to be SHI.

When consent is on record, Humana Healthy Horizons will display all member information on the provider portal at **Availity Essentials** and any health information exchanges. Please explain to your patients that if they do not consent to let Humana Healthy Horizons share this information, the providers involved in their care may not be able to effectively coordinate their care. When a member does not consent to share this information, a message displays on the provider portal to indicate that all of the member's health information may not be available to all providers.

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 provider, an attorney, a relative or some other person the member specifies.

LDH requirements regarding 24/7 PCP coverage

The referring PCP is responsible for arranging for coverage of services, consultation or approval for referrals by Medicaid-enrolled providers who accept Medicaid reimbursement. This referred coverage shall consist of an answering service, call forwarding feature, provider call coverage or other customary means approved by LDH. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number. The PCP arranges for coverage of primary care services during absences due to vacation, illness or other situations in which the PCP is unable to provide services. A Medicaid-eligible PCP must provide coverage.

For the best interest of our members and to promote their positive healthcare outcomes, Humana Healthy Horizons supports and encourages continuity of care and coordination of care between medical providers as well as between medical providers and behavioral health providers.

Americans with Disabilities Act (ADA)

All Humana Healthy Horizons-contracted healthcare providers must comply with the federal ADA, as well as all applicable state and/or federal laws, rules and regulations. More details are available in the Humana Healthy Horizons in Louisiana provider agreement under "Compliance with Regulatory Requirements."

Humana Healthy Horizons in Louisiana develops individualized care plans that take into account members' special and unique needs. Healthcare providers with patients who require interpretive services can call **1-877-320-1235** or email **accessibility@humana.com** with date, time, provider phone number and location for appointment. Please do not include any patient health information. This is not needed when emailing.

Members who need interpretation services can call the number on the back of their member ID card or visit Humana's website at **Humana.com/accessibility-resources**.

Cultural competency

Participating providers are expected to provide services in a culturally competent manner that includes, but is not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient.

Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the ADA and the Rehabilitation Act of 1973.

Humana Healthy Horizons recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. We are committed to developing strategies that eliminate health disparities and address gaps in care.

A workshop supported by the National Institutes of Health and the Agency for Healthcare Research and Quality in 2023 found that a "health workforce that reflects the national cultural and language diversity and the lived experiences and cultural context of the communities that it serves is necessary to advance equity."[3]

Communication is crucial to delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers. Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine healthcare-seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and improvements in communication with a growing number of diverse patients.

Humana Healthy Horizons offers a number of initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources. To request assistance with non-English languages for patients, please call **1-877-320-2233** or email

accessibility@humana.com and a Humana Concierge Service for Accessibility representative will contact you to set up service for Humana Healthy Horizons patients. Other initiatives give providers resources and materials, including health-related tools from organizations that support awareness of gaps in care and information on culturally competent care.

You may view a complete copy of Humana's Cultural Competency Plan on Humana's website at **Language assistance and diversity**. To request a paper copy of Humana's Cultural Competency Plan, please call Humana Healthy Horizons Customer Care at **1-800-4HUMANA (448-6262)** or call your provider contracting representative. A copy of Humana's Cultural Competency Plan will be provided at no charge.

Advance directives

PCPs are responsible for discussing advance medical directives at the first medical appointment with adult members who are 18 or older and of sound mind. The discussion should subsequently be charted in the member's permanent medical record. A copy of the advance directive should be included in the member's medical record along with other mental health directives.

The PCP should discuss potential medical emergencies with the member and document that discussion in the member's medical record.

Mental health advance directive

Mental health advance directives allow members to make decisions related to their mental health treatment in advance. This includes but is not limited to psychoactive medication, short-term (not to exceed 15 days) admission to a treatment facility, electroshock therapy and outpatient services.

- The mental health advance directives will only be considered valid if 2 providers believe the member is incapacitated and unable to make an informed decision. The document also allows the member to appoint someone as a representative to make treatment decisions.

A copy of the mental health advance directive should also be included in the member's permanent medical record and shared with all providers involved in the member's treatment plan.

Chapter 12: Care management programs

Care management

Humana Healthy Horizons' 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: CHWs, housing specialists, 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 the provider to ensure the best and most comprehensive care for our members. This collaborative approach can support patient's health and well-being by:

- Reducing admission and readmission risks
- Managing anticipatory transitions
- Engaging noncompliant members
- Reinforcing medical instructions
- Assessing SDOH

We encourage and invite providers to take an active role in the patient care management program, participate in the development of a comprehensive care plan and become part of an MDT by reaching out to our care management team at **1-800-448-3810 (TTY: 711)**.

Member plans of care and health needs assessments are viewable on Humana Healthy Horizons' provider portal and are available upon request by calling our care management team at **1-800-448-3810 (TTY: 711)**.

Referrals

We offer individualized member education and support for many conditions and needs, including assistance with housing and accessing community support.

Direct access for member care management referrals and needs assistance is available by calling **1-800-448-3810 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m.; by faxing **1-833-981-0204**; or emailing us at **LAMCDCaseManagement@humana.com**.

A referral form is available at **Provider documents and forms—Louisiana Medicaid for providers | Humana** to make referring easier via email. We encourage you to refer members who might need individual attention to help them manage special healthcare challenges.

Intensive complex care management for high-risk members

High-risk members require the most focused attention to support their clinical care needs and address SDOH. Members involved in this level of care management receive monthly contacts to review plans of care and quarterly reassessment for changing needs. This includes in-person and telephonic interventions.

Care management activities may integrate CHWs and peer or specialist support. Case managers focus on implementing the member's plan of care, preventing institutionalization and other adverse outcomes, and supporting the member in self-managing the member's care goals.

Direct access for member care management referrals and needs assistance is available from 8 a.m. to 5 p.m., Monday through Friday, by calling **1-800-448-3810 (TTY: 711)**, faxing to **1-833-981-0204** or emailing us at **LAMCDCaseManagement@humana.com**.

Care management for medium-risk members

Medium-risk 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 reassessment.

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 reassessment, along with plan of care updates through in-person or telephonic outreach.

Transitional care management

Care management activities may integrate CHWs and peer or specialist support as members transition from one care setting to another or back into their community. Case managers focus on implementing the member's plan of care, preventing institutionalization and other adverse outcomes, and supporting the member in self-managing the member's care goals. Specifically, transitional care management also includes:

- Support for members as they transition from inpatient care to the community
- Follow-up appointment support
- Reliable delivery of at-home and/or post-discharge items
- A review of discharge instructions and medication changes

HumanaBeginnings prenatal program

Humana's HumanaBeginnings® program provides perinatal and neonatal care management utilizing a specialized staff. Experienced maternity care nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members.

The expertise offered by the staff includes a focus on patient education and support and involves in-person and telephonic contact with members and providers. We encourage our prenatal care providers to notify the care management team at **1-800-448-3810 (TTY: 711)** when a member with a high-risk pregnancy is identified or when they would like to refer a patient to the program.

We encourage providers to fax the state **Medicaid Notification of Pregnancy Form** to **1-833-982-0053**.

Chapter 13: 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 Healthy Horizons must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the HHS-OIG. The following population health programs are offered to Humana Healthy Horizons 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 on Humana Healthy Horizons receiving the provider's claim for services rendered.

Humana Healthy Horizons recommends that all providers submit their claims on behalf of a member by end of December 2025. This allows members time to redeem their rewards.

The Go365 for Humana Healthy Horizons mobile app is available for members to download from Android and iPhone app stores. After members register their account, they can access the app's features and begin earning and redeeming rewards with points accumulated after completing key activities.

Activity	Reward details	
Annual wellness visit	Complete an annual wellness visit with a primary care physician (PCP); available to members 3 and older.	$25 in rewards per year
Behavioral health follow-up visit	Have a follow-up visit within 7 days after hospital discharge for a behavioral health diagnosis; available to all members.	$25 in rewards per hospitalization
Breast cancer screening	Get a mammogram; available to female members 40 and older.	$25 in rewards per year
Cervical cancer screening	Get a cervical cancer screening as part of a routine pap smear; available to members 21 and older.	$25 in rewards per year
Chlamydia screening	Get a chlamydia screening when sexually active or as recommended by your healthcare provider; available to all female members.	$25 in rewards per year
Colorectal cancer screening	Get a colorectal cancer screening as recommended by your PCP; available to members 45 and older.	$25 in rewards per year

Activity	Reward details	
Comprehensive diabetic screening	Get an annual HbA1c and blood pressure screening; available to diabetic members 18 and older.	$25 in rewards per year
Diabetic retinal eye exam	Get a retinal eye exam; available to diabetic members 18 and older.	$25 in rewards per year
Digital onboarding	Download the Go365 for Humana Healthy Horizons app and complete registration; available to all members.	$20 in rewards per lifetime
Fall prevention video	Watch a video on the Go365 app to reduce your risk of falls; available to members 55 and older.	$10 in rewards per year
Flu shot	Get the flu vaccine. If given by someone other than a provider or at a pharmacy, upload a photo for documentation in the Go365 app; available to all members.	$20 in rewards per year
Health needs assessment (HNA)	Complete within 90 days of enrollment with Humana Healthy Horizons. The HNA can be done in 1 of 4 ways: • Complete through the Go365 for Humana Healthy Horizons app. • Fill out and send back the HNA in the envelope from your welcome kit. • Call 1-800-448-3810 (TTY: 711), Monday – Friday, 7 a.m. – 7 p.m. • Create a MyHumana account and submit the HNA online (available via desktop only). This is available to all members.	$30 in rewards per lifetime
High-intensity care of substance use disorder (SUD)	Have a follow-up visit within 7 days after discharge from inpatient care, residential treatment or a detoxification visit; available to all members.	$25 in rewards per hospitalization
Human papillomavirus (HPV) vaccine	Complete both doses to receive the reward; available to members age 9–13.	$20 in rewards per lifetime
Level-of-care video	Watch this video in the Go365 app about when to access the emergency room (ER); available to members 19 and older.	$10 in rewards per year
Notification of pregnancy (NOP)	Notify Humana of a pregnancy prior to delivery in the Go365 app. This is available to pregnant female members. Members 13 and under must call to notify Humana.	$25 in rewards per pregnancy, max $50 per year
Postpartum visit	Complete 1 postpartum visit within 7 and 84 days after delivery; available to pregnant female members.	$25 in rewards per pregnancy

Activity	Reward details	
Prenatal visit	Complete up to 10 prenatal visits; available to pregnant female members.	$10 in rewards per visit, up to 10 visits, max $100 per pregnancy
Tobacco and vaping cessation coaching	Work with a wellness coach over the phone to quit smoking or vaping. Members earn: • $25 for completing 2 calls within 45 days of enrolling in coaching • $25 for completing 6 more calls (8 total) within 12 months of your first coaching session Enroll by calling 1-866-270-4223 (TTY: 711). When prompted, select option 1. This is available to members 12 and older.	Up to $50 in rewards per year
Weight management coaching	Work with a wellness coach over the phone to reach or keep a healthy weight. Members earn: • $15 for enrolling and submitting a PCP form • $15 for completing a total of 6 calls, within 12 months of enrolling To enroll, call 1-866-270-4223 (TTY: 711). When prompted, select option 2. This is available to members 12 and older.	Up to $30 in rewards per year

Once members are enrolled, Humana Healthy Horizons 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 OTC drugs). All programs, including incentives and rewards, are made available to 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 nontransferable to other MCOs. Members lose access to earned incentives and rewards upon voluntary disenrollment from Humana Healthy Horizons or if Medicaid eligibility is lost for more than 180 days.

If you would like to refer a member for any of the above programs, please call our care management department at **1-800-448-3810 (TTY: 711)** or email a referral to **LAMCDCaseManagement@humana.com**.

Interpreter services

Hospital and nonhospital providers are required to abide by federal and state regulations regarding sections 504 and 508 of the Rehabilitation Act of 1973, Executive Order 13166 and Section 1557 of the ADA. For deaf members, the Affordable Care Act includes providing in-person, phone or video remote interpretation services in at least 150 non-English languages.

These services are available at no cost to the patient or member per federal law. If you need assistance in fulfilling this obligation, please call **1-877-320-1235**.

Health education

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

Chapter 14: Value-added benefits

Value added benefits are those services offered by Humana Healthy Horizons 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 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 offers the following value-added benefits:

Value-added benefits	Description
Baby and me meals	Up to 2 precooked home-delivered meals per day for 10 weeks for pregnant women who are high risk. Care Manager approval required.
Convertible car seat or portable crib	All pregnant members who enroll and actively participate in our HumanaBeginnings care management program and complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings care manager can select 1 convertible car seat or portable crib per infant, per pregnancy.
Dental services (age 21 and older)	Up to a $500 allowance toward services such as routine dental exams, X-rays, cleanings, filings, and extractions with in-network providers.
Disaster preparedness meals	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.

Value-added benefits	Description
GED testing (age 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 a test pass guarantee to provide members multiple with 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	Asthmatic members in our Care/Disease Management programs can receive an allowance of up to $200 per year to alleviate the cost of services such as allergen-free bedding, carpet cleaning and/or an air purifier. Care Manager approval required.
Housing assistance (age 18 and older)	Up to $500 per member ages 18 and older per year (unused allowance does not roll over to the next year) to assist with the following housing expenses: Apartment rent or mortgage payment (late payment notice required) Utility payment for electric, water, or gas (late payment notice required) Trailer park and lot rent if permanent residence (late payment notice required) Moving expenses via a licensed moving company when transitioning from a public housing authority Plan approval required. The member must not live in a residential or nursing facility. Funds will not be paid directly to the member. If the bill is in the spouse's name, a marriage certificate may be submitted as proof.
Newborn circumcision (age 0–12 months)	Up to 12 months of age or as medically necessary, once per lifetime.
Nonemergency medical transportation (NEMT) (age 18 and older)	Rides up to 30 miles to medical appointments with a stop at a pharmacy for medications.

Value-added benefits	Description
Nonmedical transportation (NMT) (age 18 and older)	Up to 15 round trips (or 30 one-way trips) up to 30 miles for non-medical transportation per year to locations such as social support groups, wellness classes, WIC and SNAP appointments, food banks, and applicable value added benefit services offered. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas, and churches.
OTC pharmacy allowance	Up to $75 per quarter allowance that enables members to purchase products that support common occurring conditions such as: Pain relivers Diaper rash cream Cough and cold relief medicine First aid equipment that does not require a prescription Unused amounts do not roll over from one quarter to the next.
Postdischarge meal	14 refrigerated home-delivered meals are provided following discharge from an inpatient or residential facility, limited to 4 discharges per year.
Respite care for homeless program (males ages 18 and older)	The Medical Respite program ensures member recovery and stabilization, successful member integration back into the community, and reduces unnecessary emergency department visits and hospital admissions.
Smartphone services	Smartphones can provide easy access to health-related information and enable members to stay connected to their care team and health plan. Humana members who qualify for the Federal Lifeline program are eligible to receive a free smartphone with monthly talk minutes, text and data.
Sports physical (age 6–18 years)	1 sports physical per year.
Tobacco and vaping cessation coaching (age 12 and older)	Tobacco and Vaping Cessation Coaching is focused on helping members aged 12 and older with stopping their usage of nicotine products. The program is designed as a monthly engagement for a total of 8 coaching calls, but the member has 12 months to complete the program if needed. The program also offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT) for members aged 18 and older.

Value-added benefits	Description
Vision services (age 21 and older)	1 eye exam is offered per year. Up to a $100 annual allowance for 1 set of glasses (frames and lenses) and/or contacts. Member pays any cost over $100.
Weight management coaching (age 12 and older)	Weight Management Coaching helps members who are 12 and older achieve or maintain a healthy weight. Upon receiving physician clearance, the member can complete six (6) sessions with a Wellness Coach; approximately one (1) call per month for a period of six (6) months.
YMCA gym membership	Free one-year membership at any participating YMCA.
Youth development and recreation (age 4–8 years)	Members ages 4 to 18 can receive reimbursement of up to $250 annually for participation in activities such as: - YMCA - Boys and Girls Club - Swim lessons - Computer coding classes - Music lessons

Chapter 15: Pharmacy

Humana Healthy Horizons provides coverage of medically necessary medications prescribed by Louisiana Medicaid licensed prescribers. Humana Healthy Horizons adheres to state and federal regulations on medication coverage for our members. The member's prescription drug benefit is provided by Humana Pharmacy Solutions.

Utilization Management

Covered drugs and associated drug Utilization Management requirements, such as prior authorization, quantity limits, etc., are included in the PDL.

- Prior authorization: The medication must be reviewed using a criteria-based approval process prior to a coverage decision. Prior authorizations for the pharmacy benefit are completed by Humana Pharmacy Solutions and can be requested by:
  - Phone: 1-800-555-CLIN (1-800-555-2546)
  - Fax: 1-877-486-2621
  - Online: **CoverMyMeds**
- Drug safety limits: Facilitate the appropriate, approved label use of various classes of medications (e.g., drug interactions, opioid limits, therapeutic duplication).
- Generic substitution: Generic drugs should be dispensed when available.
- Quantity limits: Restrict the maximum quantity of a medication during a certain period of time to help ensure safe use of a medication based on recommended dosing guidelines.

Prior Authorizations for physician-administered drugs other than a vaccine that is typically administered by a healthcare provider in a provider's office or other outpatient clinical setting can be obtained by:

- Phone: **1-866-461-7273**
- Fax: **1-888-477-3420**

Coverage determinations and exceptions

Providers may request coverage determinations, including medication prior authorization, step therapy, quantity limits and formulary exceptions, via the following methods:

- Obtain forms on our **Prior Authorization.**
- Submit requests electronically by visiting **Covermymeds.com**.
- Submit requests by fax to **1-877-486-2621**.
- Call Humana Clinical Pharmacy Review (HCPR) at **800-555-CLIN (2546)**.

The coverage determination decision is based on medical necessity and is communicated within 24 hours of receipt of the request from the prescriber.

Medication appeals

If Humana Healthy Horizons denies the member's coverage determination by making an appeal on behalf of the member. Please review the member grievance and appeals section of this manual for details on how to submit appeals.

Peer-to-peer

If providers prefer to have a discussion with 1 of our pharmacists or regional medical directors before submitting an appeal, they may initiate a peer-to-peer request by calling **844-330-7734**, Monday – Friday, 7 a.m. – 5 p.m., Central time, and leaving a message that includes:

- Prescriber contact information and best time to contact
- Referenced patient name, date of birth and evidence of coverage information
- Prescription drug requested and reason for the call

Note: The person-to-person discussion is not considered part of the appeal process and, depending on the outcome, providers may still request a formal appeal.

Electronic prescribing

Through our participation in the SureScripts network, our pharmacy benefit manager (PBM), eligibility, formulary and member medication history are available through every major electronic health record (EHR) or e-prescribing (eRx) vendor, including Allscripts, Epic, Cerner, athenahealth and DrFirst. Prescribers with EHR or eRx can view real-time clinical information about the safety alert messaging and prior authorization requirements.

Coverage limitations

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

- Agents used for anorexia, weight gain or weight loss (orlistat covered only)
- Agents used to promote fertility
- Agents used for symptomatic relief of cough and colds, except for antihistamine and antihistamine/decongestant combination products

- Agents used for cosmetic purposes or hair growth
- Agents used for erectile dysfunction
- Compound prescriptions (mixtures of 2 or more ingredients; the individual drugs will continue to be reimbursed)
- DESI drugs (refer to those drugs the FDA has proposed to withdraw from the market because they lack substantial evidence of effectiveness)
- Nonlegend or OTC drugs or items with some exceptions when accompanied by a prescription and on the **Louisiana Department of Health PDL**.

Immunizations

Humana Healthy Horizons covers ACIP vaccines.

- For members age 18 and younger, vaccinations are provided free of charge through the Louisiana Immunization Program/Vaccines for Children Program.
- For members age 19 and older, vaccines and vaccine administration are covered, however additional point-of-sale edits may apply

Copay

Medications may have a small copay for members 21 and older based on calculated state payment. The following table shows the copay amounts:

Monthly income	Copay
When 5% of family's monthly income is spent on copays	$0
Medication cost	**Copay**
$5.00 or less	$0
$5.01–$10.00	$0.50
$10.01–$25.00	$1.00
$25.01–$50.00	$2.00
$50.01 or more	$3.00

However, there are no copays for the following members:

- Individuals younger than 21
- Pregnant women
- Individuals who are inpatients in long-term care facilities or other institutions
- Family planning services and supplies
- Emergency services
- Native Americans

- Alaskan Eskimos
- Women who are receiving services due to breast or cervical cancer
- Beneficiaries receiving hospice services
- USPSTF A&B
- Enrollees of a home and community based waiver

Continuity of care

We want to make the enrollment or transition into our plan as easy as possible for our members. For drugs that require a coverage determination, we may allow a temporary supply of a drug during the first 90 days of enrollment. You should receive a notice of the transition event on record when your patient receives a transition claim.

Medication Therapy Management

Humana Healthy Horizons offers a Medication Therapy Management (MTM) program that helps ensure patients achieve the best possible outcomes from their medications. The patient-centered MTM program promotes collaboration between the pharmacist, patient and prescriber to optimize safe and effective medication use. The goal of this program is to optimize therapeutic outcomes by focusing on safety, effectiveness, lower-cost alternatives and adherence.

Prescribers with questions about the program can call **1-888-210-8622 (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., Central time.

Network pharmacies

Our pharmacy directory gives providers a complete list of network pharmacies that agreed to fill covered prescriptions for members. Providers and members can access our Pharmacy Directory at **Humana.com/PharmacyFinder**, and members also can find our Pharmacy Finder tool by visiting **Humana.com**.

Pharmacy lock-in program

The lock-in program is designed for individuals enrolled in Louisiana Medicaid who need help managing their use of prescription medications. It is intended to limit overuse of benefits while providing an appropriate level of care for the member.

Humana Healthy Horizons members who meet the program criteria will be locked in to one pharmacy and/or one prescriber (group) and up to three specialty prescribers are allowed. A specialty pharmacy will be added on an as-needed basis. The lock-in program is required by LDH.

Humana Healthy Horizons monitors claim activity for signs of misuse or abuse in accordance with state and federal laws. If 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.

Members identified to be enrolled in the lock-in program receive written notification from Humana Healthy Horizons, along with the designated lock-in pharmacy and/or prescriber's (group) information.

Over-the-counter health and wellness

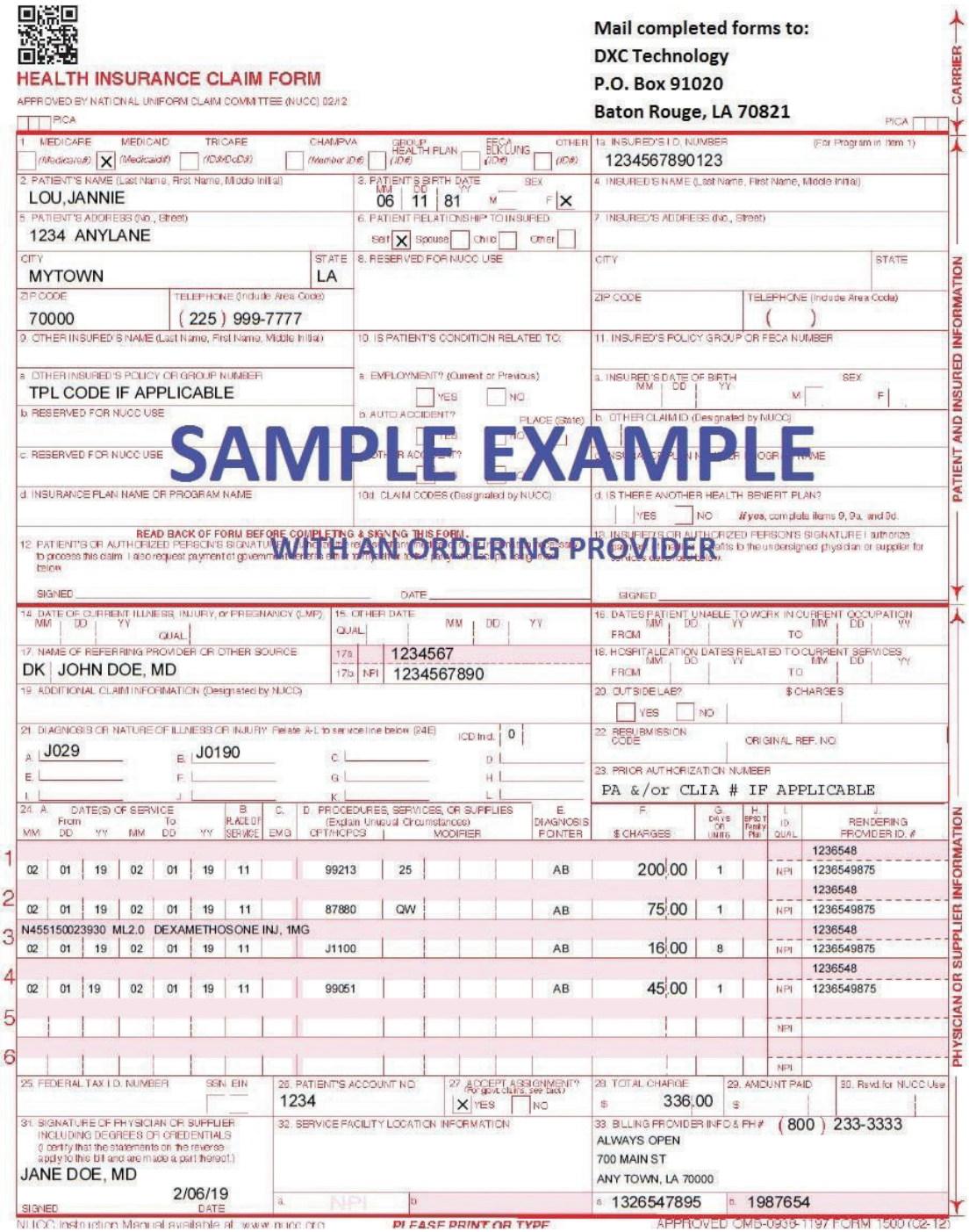
Humana Healthy Horizons members have an expanded pharmacy benefit, which provides a $75 per-quarter allowance to spend on OTC health and wellness items. These OTC products will be sent by mail within 10–14 working days after the order is made. There is no charge to the member for shipping.

References

1. "Public Policy Statement: Definition of Addiction," American Society of Addition Medicine, last accessed April 9, 2024, **1definition_of_addiction_long_4-11.pdf**.
2. "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, last accessed April 9, 2024, **https://www.samhsa.gov/find-help/recovery**.
3. Francis K. Amankwah, Joe Alper, and Sharyl J. Nass. 2024. "Unequal Treatment Revisited: The Current State of Racial and Ethnic Disparities in Health Care." Washington, DC: National Academies Press.

Appendix
LDH clean claim samples

Sample of professional claim form—revised Aug. 15, 2019



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Mail completed forms to:
DXC Technology
P.O. Box 91020
Baton Rouge, LA 70821

CARRIER

1. MEDICARE [ ] MEDICAID [X] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
1a. INSURED'S I.D. NUMBER: 1234567890123
2. PATIENT'S NAME: LOU, JANNIE
3. PATIENT'S BIRTH DATE: 06 11 81 SEX: F [X]
4. INSURED'S NAME:
5. PATIENT'S ADDRESS: 1234 ANYLANE
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS:
CITY: MYTOWN STATE: LA
8. RESERVED FOR NUCC USE
ZIP CODE: 70000 TELEPHONE: (225) 999-7777
9. OTHER INSURED'S NAME:
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 SEX
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? [ ] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a, and 9d.

SAMPLE EXAMPLE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize ... 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 _____

WITH ANORDERING PROVIDER

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
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		NPI	1236548 / 1236549875
2	02	01	19	02	01	19	11		87880	QW	AB	75.00	1		NPI	1236548 / 1236549875
3	N455150023930 ML2.0 DEXAMETHOSONE INJ, 1MG														
	02	01	19	02	01	19	11		J1100		AB	16.00	8		NPI	1236548 / 1236549875
4	02	01	19	02	01	19	11		99051		AB	45.00	1		NPI	1236548 / 1236549875
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO. 1234
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] 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
2/06/19
SIGNED DATE

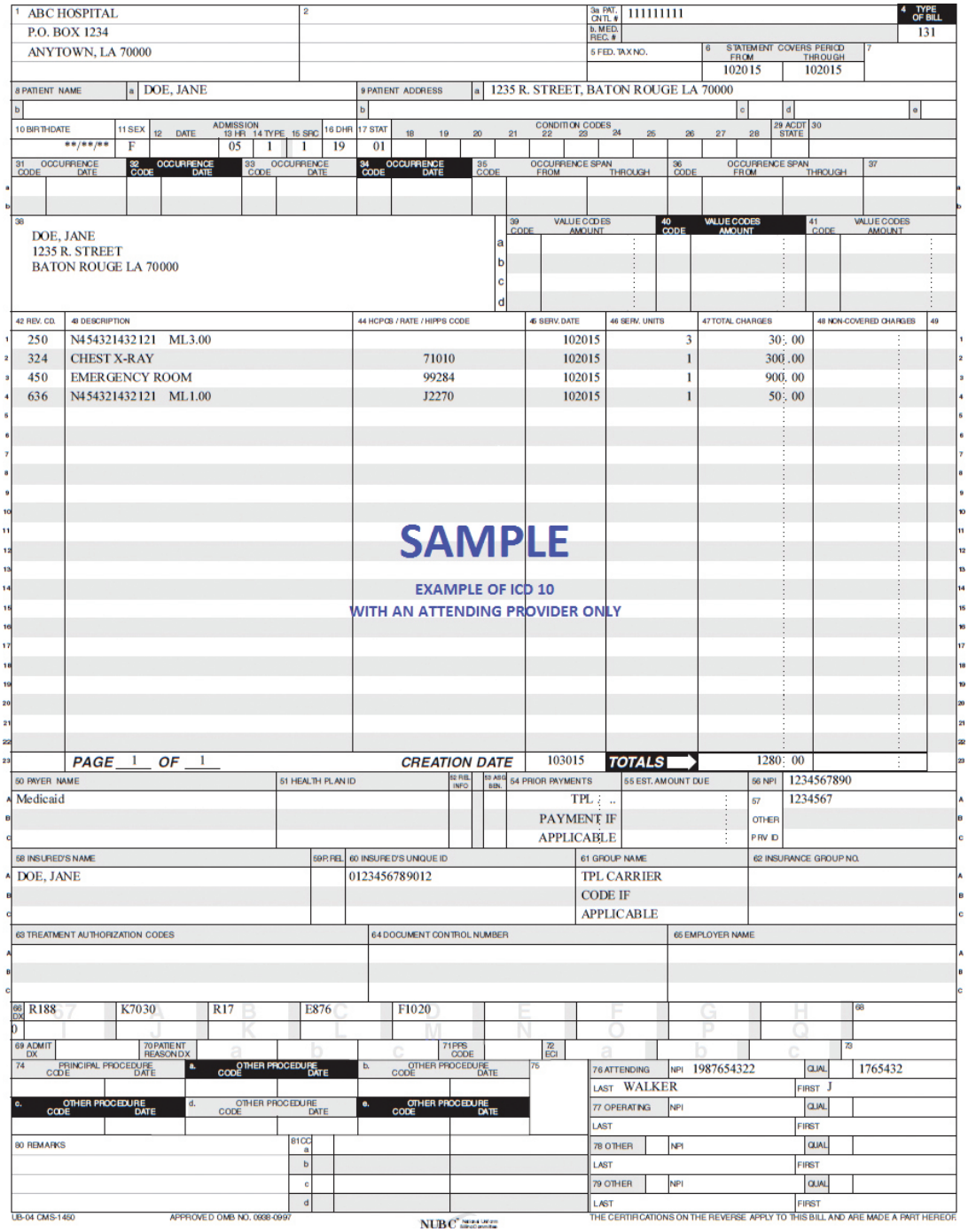
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # (800) 233-3333
ALWAYS OPEN
700 MAIN ST
ANY TOWN, LA 70000
a. 1326547895 b. 1987654

PHYSICIAN OR SUPPLIER INFORMATION

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

Sample outpatient hospital claim form with an attending provider only (with ICD-10 diagnosis code dates on or after Oct. 1, 2015)



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

3a PAT. CNTL # 111111111
4 TYPE OF BILL 131
6 STATEMENT COVERS PERIOD FROM 102015 THROUGH 102015

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
1	250	N454321432121 ML3.00		102015	3	30 00	
2	324	CHEST X-RAY	71010	102015	1	300 00	
3	450	EMERGENCY ROOM	99284	102015	1	900 00	
4	636	N454321432121 ML1.00	J2270	102015	1	50 00	
23		PAGE 1 OF 1	CREATION DATE	103015	TOTALS	1280 00	

SAMPLE
EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

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

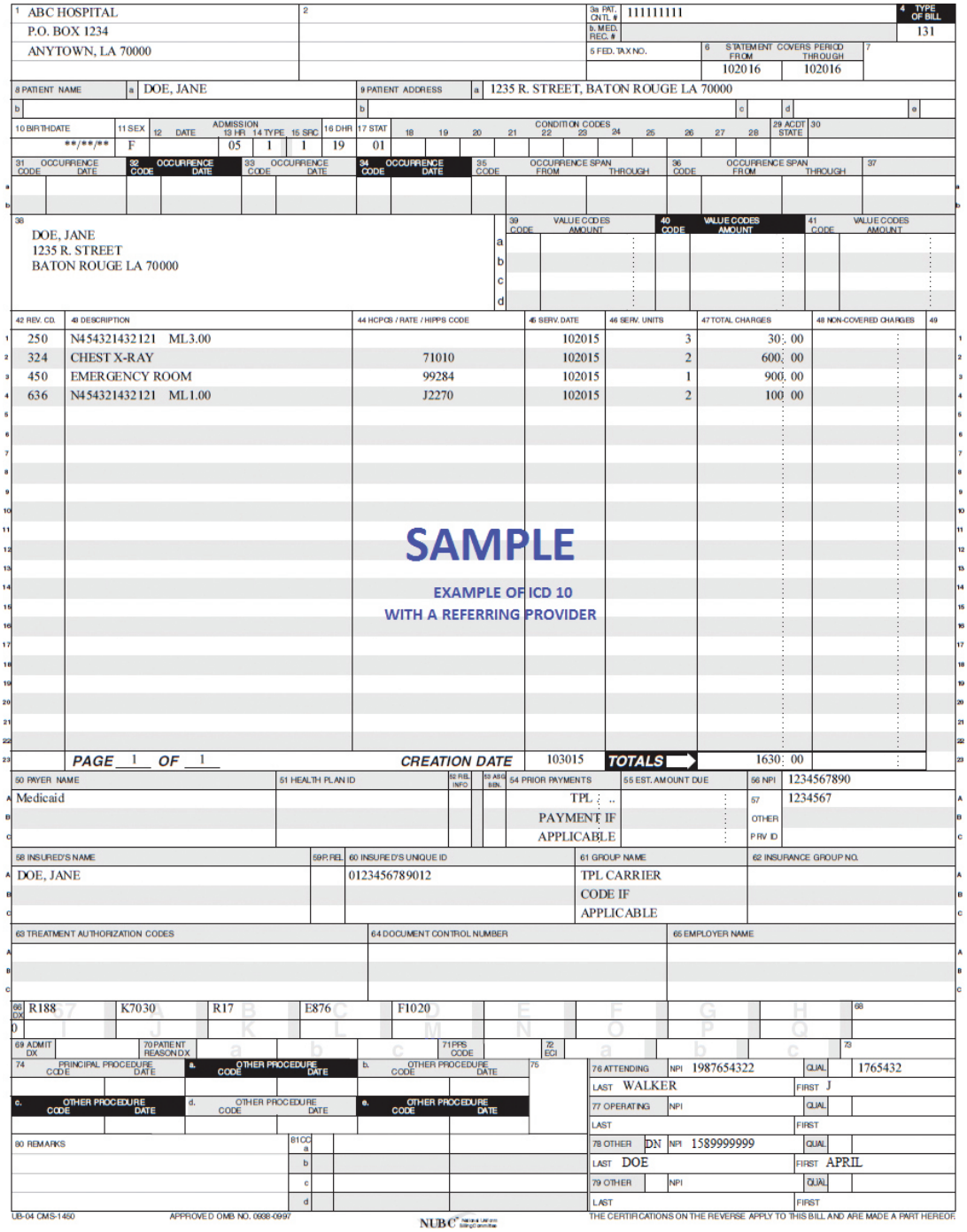
58 INSURED'S NAME: DOE, JANE
60 INSURED'S UNIQUE ID: 012345678901 2
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE

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

76 ATTENDING NPI 1987654322 QUAL 1765432
LAST WALKER FIRST J

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 with a referring provider (with ICD-10 diagnosis code dates on or after Oct. 1, 2015)



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

10 BIRTHDATE **/**/** | 11 SEX F | ADMISSION 12 DATE 05 | 13 HR 1 | 14 TYPE 1 | 15 SRC | 16 DHR 19 | 17 STAT 01 | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

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
DOE, JANE
1235 R. STREET
BATON ROUGE LA 70000

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	250	N454321432121 ML3.00		102015	3	30 00	
2	324	CHEST X-RAY	71010	102015	2	600 00	
3	450	EMERGENCY ROOM	99284	102015	1	900 00	
4	636	N454321432121 ML1.00	J2270	102015	2	100 00	
23		PAGE 1 OF 1	CREATION DATE	103015	TOTALS	1630 00	

SAMPLE
EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

50 PAYER NAME: A Medicaid | 51 HEALTH PLAN ID | 52 REL INFO | 53 ASG BEN. | 54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE | 55 EST. AMOUNT DUE | 56 NPI 1234567890 | 57 OTHER PRV ID 1234567

58 INSURED'S NAME: A DOE, JANE | 59 P. REL | 60 INSURED'S UNIQUE ID: 012345789012 | 61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

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

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

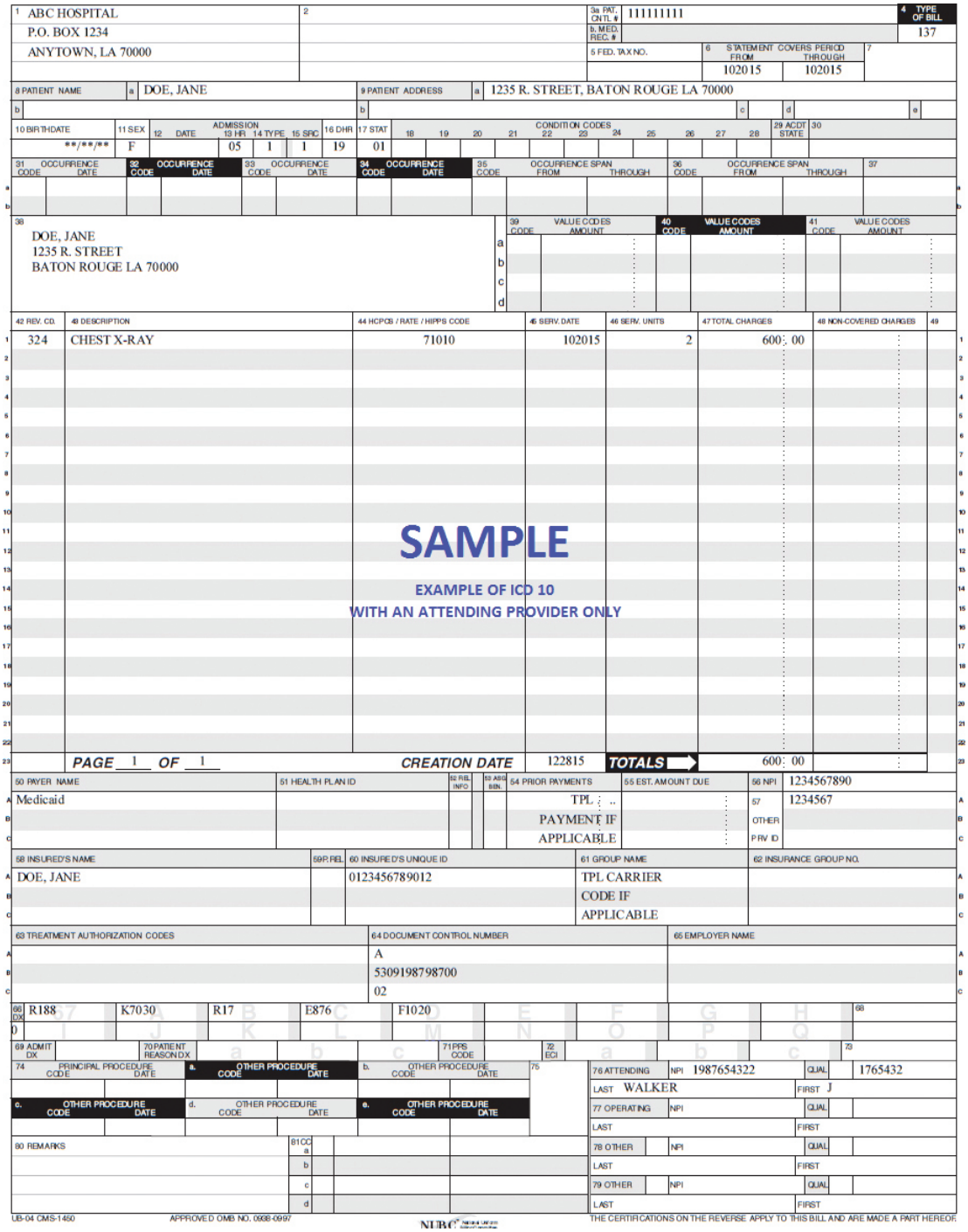
74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

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

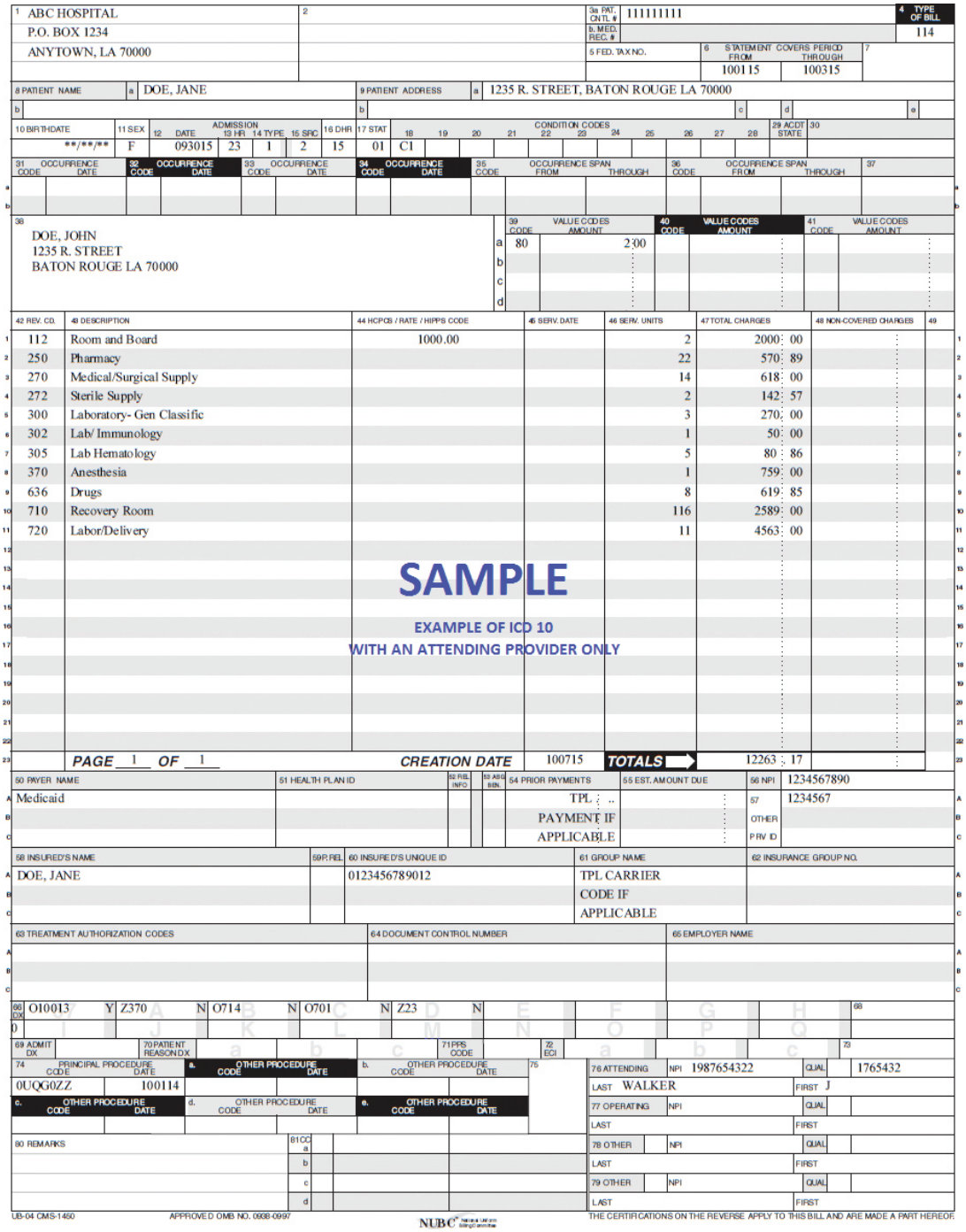
80 REMARKS | 81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample outpatient hospital claim form adjustment with an attending provider only (with ICD-10 diagnosis code dates on or after Oct. 1, 2015)



Sample inpatient hospital claim form split billed with an attending provider only (with ICD-10 diagnosis code dates on or after Oct. 1, 2015)



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

3a PAT. CNTL # 111111111
4 TYPE OF BILL 114
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 100315

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

10 BIRTHDATE **/**/** | 11 SEX F | ADMISSION 12 DATE 093015 | 13 HR 23 | 14 TYPE 1 | 15 SRC 2 | 16 DHR 15 | 17 STAT 01 | CONDITION CODES 18 C1

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

39 VALUE CODES a 80 AMOUNT 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
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	
23		PAGE 1 OF 1		CREATION DATE 100715	TOTALS	12263 17	

SAMPLE
EXAMPLE OF ICD 10
WITH AN ATTENDING PROVIDER ONLY

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

58 INSURED'S NAME A DOE, JANE
60 INSURED'S UNIQUE ID 012345678912
61 GROUP NAME TPL CARRIER CODE IF APPLICABLE

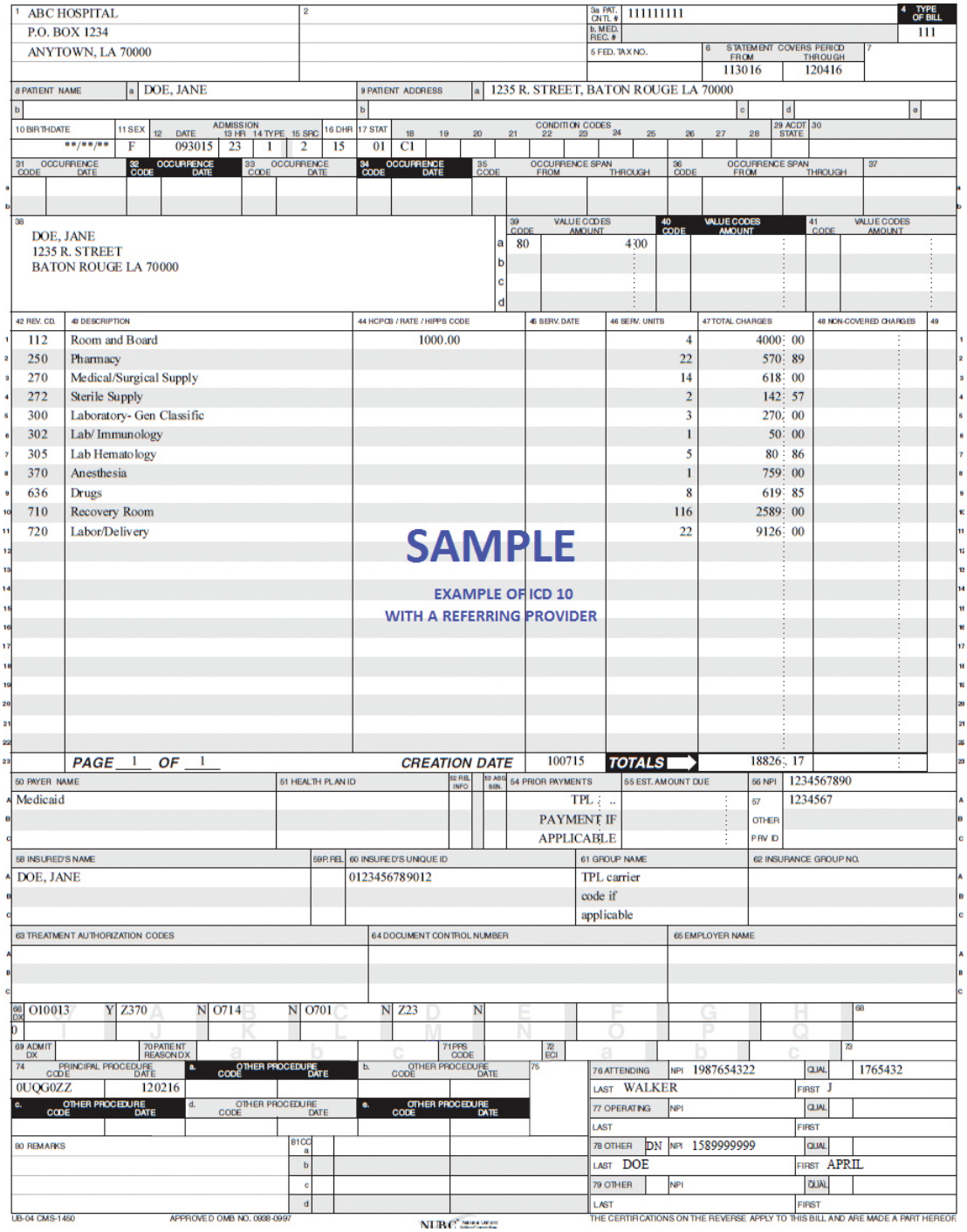
66 DX 0 O10013 | Y Z370 | N O714 | N O701 | N Z23 | N

74 PRINCIPAL PROCEDURE CODE 0UQG0ZZ DATE 100114

76 ATTENDING NPI 1987654322 QUAL 1765432
LAST WALKER FIRST J

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 not split billed with a referring provider (with ICD-10 diagnosis code dates on or after Oct. 1, 2015)



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

3a PAT. CNTL # 111111111
b. MED. REC. #
4 TYPE OF BILL 111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 113016 THROUGH 120416

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES	29 ACDT STATE	30
//**	F	093015	23	1	2	15	01	C1		

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				

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
112	Room and Board	1000.00		4	4000 00	
250	Pharmacy			22	570 89	
270	Medical/Surgical Supply			14	618 00	
272	Sterile Supply			2	142 57	
300	Laboratory- Gen Classific			3	270 00	
302	Lab/ Immunology			1	50 00	
305	Lab Hematology			5	80 86	
370	Anesthesia			1	759 00	
636	Drugs			8	619 85	
710	Recovery Room			116	2589 00	
720	Labor/Delivery			22	9126 00	
	PAGE 1 OF 1	CREATION DATE	100715	TOTALS	18826 17	

SAMPLE
EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

50 PAYER NAME	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

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

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

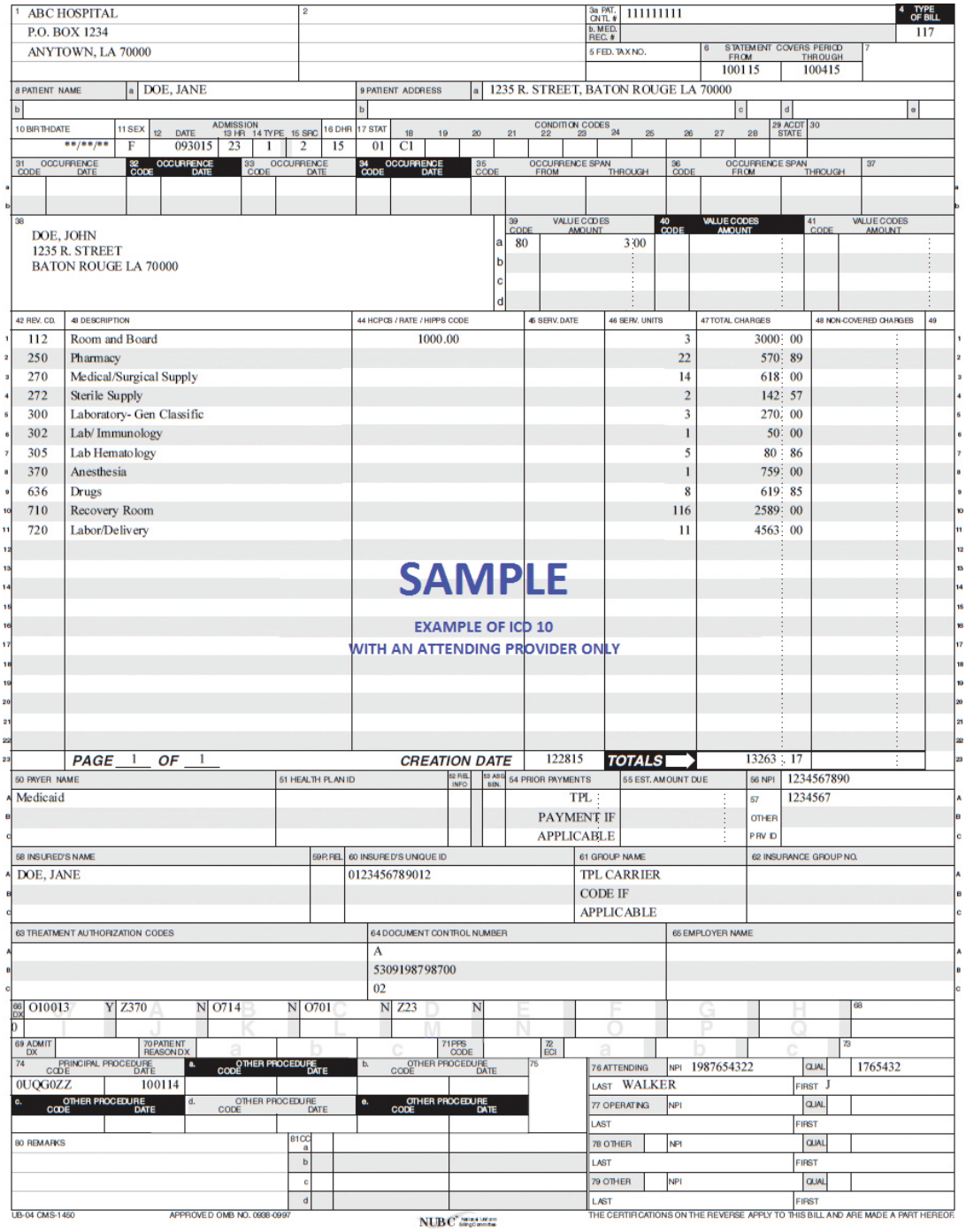
80 REMARKS

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 Oct. 1, 2015)



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

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 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	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, JOHN
1235 R. STREET
BATON ROUGE LA 70000

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
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	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		A	
B		5309198798700	
C		02	

66 DX: O10013 Y | Z370 N | O714 N | O701 N | Z23 N — 68

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 100114			
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

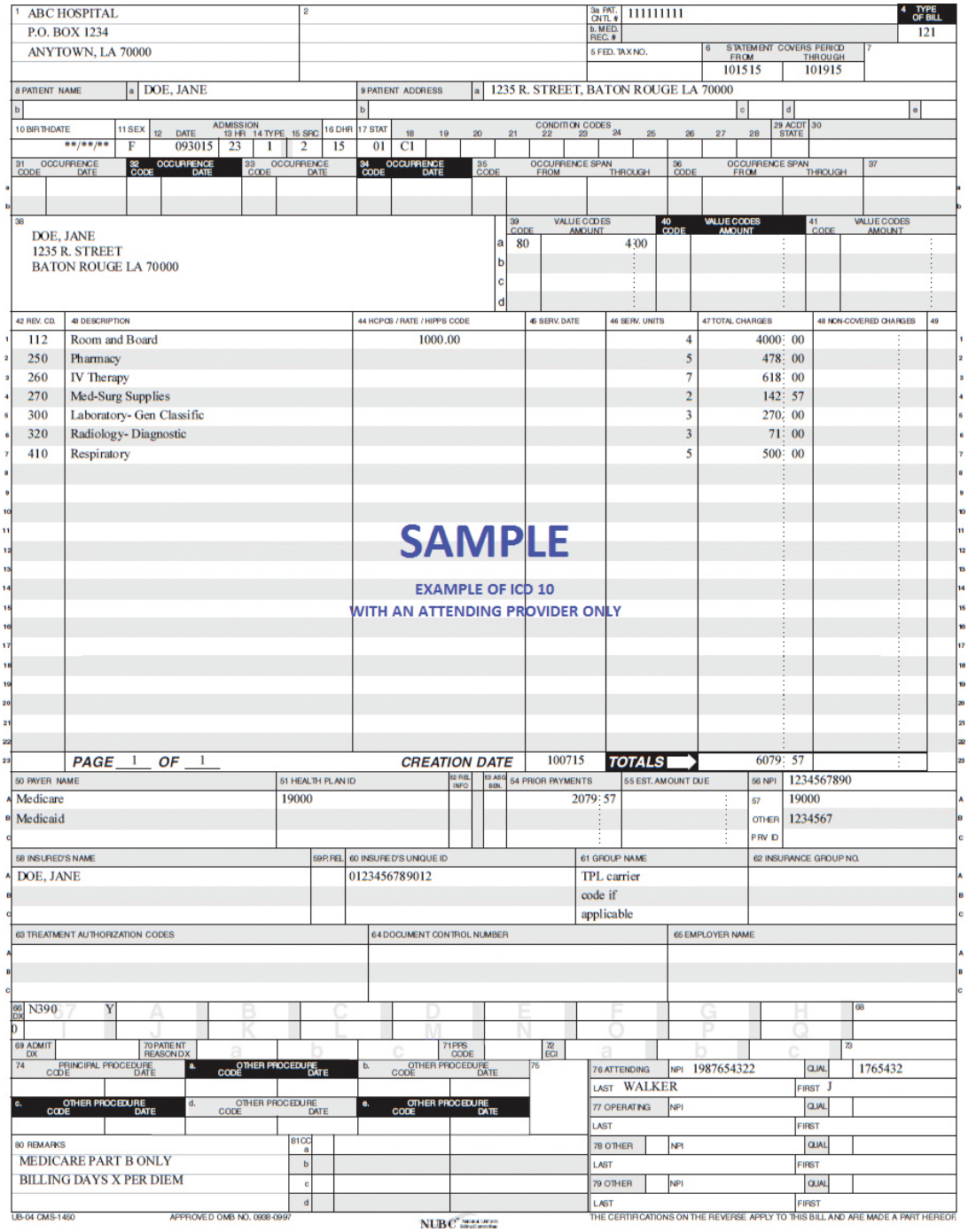
76 ATTENDING NPI 1987654322 QUAL 1765432
LAST WALKER FIRST J
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

81 CC	
a	
b	
c	
d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample inpatient hospital days x per diem claim form with an attending provider only (with ICD-10 diagnosis code dates on or after Oct. 1, 2015)



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

3a PAT. CNTL # 111111111
4 TYPE OF BILL 121
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	CONDITION CODES	29 ACDT STATE	30
//**	F	093015	23	1	2	15	01	C1		

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				

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	112	Room and Board	1000.00		4	4000: 00	
2	250	Pharmacy			5	478: 00	
3	260	IV Therapy			7	618: 00	
4	270	Med-Surg Supplies			2	142: 57	
5	300	Laboratory- Gen Classific			3	270: 00	
6	320	Radiology- Diagnostic			3	71: 00	
7	410	Respiratory			5	500: 00	
23		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	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	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JANE	012345678912	TPL carrier code if applicable	

66 DX 0 N390

76 ATTENDING NPI 1987654322 QUAL 1765432
LAST WALKER FIRST J

80 REMARKS
MEDICARE PART B ONLY
BILLING DAYS X PER DIEM

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.