Provider Orientation and Training

Information for Medicaid healthcare providers and administrators 2024

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

Humana
Healthy Horizons®
in Louisiana

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Training topics

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Training topics are based on the following:

- Humana's contract with the Louisiana Department of Health (LDH)
- Humana's policies and procedures

Training topics (con’t.)

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Humana’s Louisiana Medicaid plan

Humana’s Louisiana Medicaid plan

- Humana was awarded a managed care organization (MCO) contract to administer a Louisiana Medicaid plan effective Jan. 1, 2023.
- Humana is committed to the LDH Triple Aim approach to achieve:
  - Better health
  - Better care
  - Lower costs
- We focus on prevention and partnering with local providers to offer integrated care our members need to be healthy.
- Humana’s Louisiana Medicaid Plan is available statewide to eligible members.

Base covered services and value-added benefits

Physical health covered services

Physical health covered services include:

- Abortion services—limited
- Ambulatory surgical services
- Applied behavioral analysis therapy (age 0–20)
- Audiology services
- Chiropractic services (age 0–20)
- Durable medical equipment, prosthetics, orthotics and certain
- supplies
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services (age 0–20)
- Emergency services
- End-stage renal disease services
- Eye care and vision services
- Family planning services
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) services
- Home health extended services (age 0–20)
- Home health services
- Hospice services
- Immunizations
- Inpatient hospital services
- Laboratory and radiology services
- Medical transportation services
- Outpatient hospital services
- Pediatric day healthcare services (age 0–20)
- Personal care services (age 0–20)
- Pharmacy services
- Physician/professional services
- Podiatry services
- Pregnancy-related services
- Routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial in accordance with Section 1905(gg) of the Social Security Act of 1935
- Telemedicine
- Therapy services
- Tobacco cessation services

Covered behavioral health services

- Basic behavioral health services
- Specialized behavioral health services
- Licensed practitioner outpatient therapy
    - Mental health rehabilitation services
        - Community psychiatric support and treatment (CPST)
            - Multisystemic therapy (MST) (age 0–20)
            - Functional Family Therapy (FFT) (age 0–20)
            - Homebuilders® (age 0–20)
            - Assertive community treatment (age 18 and older)
        - Psychosocial rehabilitation (PSR)
        - Crisis intervention
- Crisis stabilization—youth (age 0-20)
- Crisis stabilization—adults (age 21 and older)
- Therapeutic group homes (TGH) (age 0–20)
- Crisis response services (age 21 and older)
    - Mobile crisis response (MCR)
    - Community brief crisis support (CBCS)
    - Behavioral health crisis care (BHCC)
- Peer support services (age 21 and older)
- Psychiatric Residential Treatment Facilities (PRTF) (age 0–20)
- Inpatient hospitalization in a freestanding psychiatric hospital (ages 0–20; 65 and older)
- Inpatient hospitalization in a distinct part psychiatric unit
- Outpatient, residential and inpatient substance use disorder services
- Medication-assisted treatment (MAT)
- Personal care services for Department of Justice (DOJ) agreement—target population (age 21 and older)
- Individual placement support services for DOJ agreement—target population (age 21 and older)

Value-added benefits

Value-added benefits are services offered by Humana that are not otherwise covered or exceed limits outlined in the Louisiana State Medicaid plan. Service descriptions and details can be found in the member handbook.

Humana offers the following value-added benefits:

- Convertible car seat or portable crib
- Dental services (age 21 and older)
- Disaster preparedness/relief meals (all ages)
- Drowning prevention classes (age 21 and younger)
- General Educational Development (GED) test preparation assistance (age 16 and older)
- Home-based interventions for asthma (all ages)
- Housing assistance (age 21 and older)
- Newborn circumcisions
- Nonemergency medical transportation (NEMT) (18 and older)
- Nonmedical transportation (NMT) (ages 18 and older)
- Over-the-counter (OTC) allowance (all ages)
- Pain management alternative–Acupuncture (age 21 and older)
- Post-discharge meals (all ages)
- Respite care for homeless program (males age 18 and older)
- Smartphone services (all ages)
- Sports physicals (age 6–18)
- Tobacco cessation program (12 and older)
- Vision services (age 21 and older)
- Weight management program
- The Y gym membership (all ages)

Excluded services

- Adult dental services, with the exception of surgical dental services and emergency dental services
- Services to individuals in intermediate care facilities for individuals with developmental disabilities (ICFs/IDDs)
- Personal care services for members age 21 and older
- Nursing facility services, with the exception of post-acute rehabilitative care provided at the discretion of the contractor when it is cost effective to do so in place of continued inpatient care as an “in lieu of service”
- Individualized education plan (IEP) services, including physical therapy, occupational therapy, speech/language therapy, audiology and some psychological therapy, provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by the 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)
- 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 OTC antihistamines, antihistamine/decongestant combinations or polyethylene glycol
  - Narcotics other than those indicated for substance use disorder when treating narcotic addiction
- Prohibited services
  - Elective abortions
  - Experimental/investigational drugs, procedures or equipment, unless approved by the Secretary of LDH
  - Elective cosmetic surgery
  - Assisted reproductive technology for treatment of infertility

Pharmacy benefit summary

Copayments

The following copays are applied based on the total cost of each drug.

$10 or less, member pays 50 cents
$10.01 to $25, member pays $1
$25.01 to $50, member pays $2
$50.01 or more, member pays $3

Once 5% of the family's monthly income is spent on copayments, members will not have copayments for the rest of the month.

OTC value-added benefit

$25 per-member, per-month OTC benefit allowance through CenterWell Pharmacy®

State-mandated Preferred Drug List (PDL)

Our plan uses LDH's formulary and coverage criteria.

Online access can be found at Louisiana Medicaid PDL

Medication Therapy Management (MTM)

MTM promotes collaboration among the pharmacist, patient and prescriber to optimize safe and effective medication use

Pharmacy lock-in program

- This program is designed for individuals who need help managing their use of prescription medications to limit overuse of benefits while providing an appropriate level of care for the member.

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

- Members who meet the program criteria will be locked in to one pharmacy and/or one prescriber (group). A specialty pharmacy will be added on an as-needed basis. The lock-in program is required by the LDH.

Contracting and credentialing

Contracting process

- Providers interested in contracting with Humana Healthy Horizons should send an email to:
  - Medical providers – LAMSProviderIntake@humana.com
  - Behavioral health providers – LABHMedicaid@humana.com
- Include the following in the email:
  - Provider, practice and/or facility name
  - Service address with phone, fax and email information
  - Mailing address (if different than service address)
  - Taxpayer Identification Number (TIN)
  - Practice specialty
  - Medicaid provider number (with corresponding registered provider and specialty provider type codes)
  - National Provider Identifier (NPI)
  - Contract type (e.g., individual, group, facility)

After request receipt and review, a provider contracting representative will contact you.

Contracting process (con’t.)

During the contracting process, the following additional information will be requested:

- Council for Affordable Quality Healthcare (CAQH®) number
- Professional liability insurance or Louisiana Patient’s Compensation Fund
- Disclosure of ownership

Credentialing and recredentialing

The Humana Healthy Horizons in Louisiana credentialing program is developed with Humana's purpose of helping members achieve their best health.

Our credentialing program leverages industry standards established by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) while incorporating requirements defined by the LDH and the Office of Behavioral Health (OBH) to create a custom credentialing program focused on creating a positive provider experience.

In accordance with Louisiana R.S. 46:460.61, Humana will complete the credentialing process within 60 days from receipt of a completed credentialing application. Humana will acknowledge receipt of applications within 5 days and notify providers if an application is determined to be incomplete within 30 days.

Recredentialing occurs at least every 3 years. Some circumstances require shorter recredentialing cycles. If we are not able to access your CAQH application during recredentialing, CAQH does not support your provider type, or the supporting documentation available via CAQH is expired or incomplete, then, in accordance with Louisiana R. S. 46:460.72, providers will receive a request to provide the necessary documentation at least 6 months prior to the 36-month anniversary date of the last credentialing cycle. Humana will make at least 3 attempts to collect complete recredentialing documentation. Attempts will be made in writing using the last email and mailing addresses we have on file for the provider.

Further details regarding Humana Healthy Horizons in Louisiana's credentialing/recredentialing requirements can be found in the Humana Healthy Horizons in Louisiana Provider Manual.

Initial credentialing
- This occurs prior to providers being made available to members.
- This includes individual practitioners and organizational providers rendering both physical health and behavioral health services.

Recredentialing
- Providers are required to be recredentialed at least every 36 months (3 years).

Ongoing monitoring
- Providers are screened for adverse events during initial credentialing, recredentialing and at least monthly between credentialing cycles.
- Providers must remain in good standing with federal, state, local, Medicare and Medicaid agencies.

Behavioral health providers
- All behavioral health providers rendering services are required to be credentialed as per LDH Behavioral Health Services Provider Manual.
- Required credentialing documents are available at Humana.com/HealthyLA.

Resources
- LDH Provider Manuals
- Louisiana Adverse Actions List Search
- Humana Healthy Horizons in Louisiana

Credentialing and recredentialing

Types of practitioners to credential:

Physical health practitioners

- Medical doctors (M.D.)
- Doctor of osteopathic medicine (D.O.)
- Oral surgeons
- Chiropractors
- Podiatrists
- Dentists
- Optometrists
- Nurse practitioners
- Physician assistants
- Other medical practitioners who are licensed, certified or registered by the state to practice independently within the scope of state regulations

Licensed mental health practitioners (LMHP)

Psychiatrists:
- M.D.
- D.O.

LMHPs:
- Medical psychologists
- Licensed psychologists
- Licensed clinical social workers
- Licensed professional counselors
- Licensed marriage and family therapists
- Licensed addiction counselors
- Behavioral health – advanced registered practice nurses
- Behavioral health – certified nurses

Provisionally licensed providers and interns rendering behavioral health services

As permitted by service and provider qualifications:

- Provisionally licensed professional counselor (PLPC)
- Provisionally licensed marriage and family therapist (PLMFT)
- Psychology intern from an internship program approved by the American Psychology Association

Unlicensed individuals rendering behavioral health services

As permitted by service and provider qualifications:

- Certain individuals employed by an accredited behavioral health and suicide prevention facility who have a bachelor's level of education from an accredited university or college in a permitted field of study
- As permitted by service and provider qualifications, certain unlicensed individuals employed by an accredited behavioral health and suicide prevention facility who meet life experience criteria

Credentialing and recredentialing

Types of organizational providers to credential:

Physical health organizational types

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Hospice providers
- Dialysis centers
- Physical therapy, occupational therapy and speech-language pathology agencies
- Rehabilitation hospitals, including outpatient locations
- Portable X-ray suppliers
- RHCs and FQHCs
- School-based clinics
- Local parish health clinics
- Indian healthcare providers

Behavioral health service provider (BHSP) types

- Hospitals
- Residential facilities
  - TGH
  - PRTF
  - Crisis stabilization for adults
- Agencies rendering evidence-based practice services
- Agencies rendering addiction services, including inpatient, residential, intensive-partial outpatient and outpatient
- Agencies rendering coordinated system of care services
- Outpatient facilities
  - Peer support
  - Personal care
  - Individual placement and support
  - RHCs and FQHCs rendering behavioral health services
  - Psychosocial rehabilitation
  - Crisis intervention
  - Crisis stabilization
  - Community psychiatric support and treatment

Contracting and credentialing status updates

To check your credentialing or contract status, please call Humana Provider Contracting to speak with a representative at 1-800-448-3810, Monday through Friday, 7 a.m. to 7 p.m.

Clinical

Utilization Management (UM)

UM helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members.

- Offers telephonic and electronic medical record (EMR) based medical necessity reviews
- Provides comprehensive discharge planning
- Promotes effective level of care based on member's individual needs
- Refers members to appropriate Humana programs

Referrals

Members may self-refer to any participating provider.
Lock-in program-eligible members are excluded from the self-referral policy.

Medicaid members may seek the following from nonparticipating providers:

- Emergency care
- Family planning services
- Care at FQHCs and RHCs

Referrals to nonparticipating providers for any service except family planning and emergency care require prior authorization.

Nonparticipating providers must be LDH-enrolled as a Medicaid provider to receive prior authorization and payment.

Prior authorizations

- Humana Healthy Horizons requires that certain services and medications receive prior authorization to facilitate care coordination and maximize member benefits. Prior authorization also confirms the services are provided according to medical necessity guidelines.
- Healthcare providers should review the Humana Healthy Horizons in Louisiana (Medicaid) Preauthorization and Notification List online at Humana.com/PAL.
- Prior authorization must be obtained before the date of service.
- Providers are required to submit notification, to the plan, of all inpatient admissions within one business day of the date of admission.
- Providers must submit notification to the plan of obstetrical admissions that exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery.
- If a member is anticipated to be in observation status beyond 48 hours, the hospital must notify the plan as soon as reasonably possible for potential authorization of an extension of hours.

Prior authorization for healthcare can be obtained by contacting the UM department online or by phone:

- Visit the provider portal at Availity Essentials
- Call 1-800-448-3810 and follow the menu prompts for authorization requests, depending on your need

Prior authorizations–online

Sign in to Humana's secure provider portal at Availity Essentials

Online submission

- Fast, easy entry of authorizations through Availity Essentials™
- Express entry feature
- Real-time responses
- Ability to add attachments
- Quick print feature

Online management

- Access to past 18 months of authorization history
- Ability to update authorizations
- Status updates on submitted authorizations

Questions can be answered either online via the provider portal or by calling Provider Services at 1-800-448-3810.

Inpatient UM

Front-end review nurse responsibilities:

- Reviews inpatient admissions for medical necessity during preauthorization or on notification of admission

Concurrent nurse responsibilities:

- Completes comprehensive discharge planning assessments on inpatient members
- Conducts medical necessity member reviews during continued inpatient stays
- Collaborates with member's healthcare team to maximize member benefits and resources and identify anticipated discharge planning needs
- Conducts medical necessity reviews for post-acute level of care requests in collaboration with medical director
- Identifies and refers members to internal Humana Healthy Horizons care management programs
- Refers member to care management team when social issues place member at risk for readmission

Pharmacy–drug prior authorization and notification

The process by which medication is supplied by a pharmacy and billed through the pharmacy benefit includes medication prior authorization, step therapy, quantity limits and medication exceptions. The PDL will be used with each prior authorization review completed by Magellan Medicaid Administration Pharmacy Services team.

The PDL is available online.

Prior authorizations are obtained through Magellan Medicaid Administration. Request prior authorizations by phone, fax or online.

- **Phone submissions**: 1-800-424-1664
- **Fax submissions**: 1-800-424-7402
- **Online submissions**: CoverMyMeds

Providers can find PA forms at Magellan Medicaid Administration forms and documents or by calling 1-800-424-1664, 24 hours a day, 7 days a week.

Access-to-care requirements

Participating primary care providers (PCPs) and specialists are required to ensure adequate healthcare accessibility:

- Available 24 hours a day, 7 days a week
- May not discriminate against members
- After-hours telephone number answered by a live agent
- Voicemail not permitted

Members should be triaged and provided care appointments within the time frames listed on the following slide.

Access to care requirements–medical care

Type of visit/admission/appointment	Access/timeliness standard
Emergency care	24 hours, 7 days a week, within 1 hour of request
Urgent nonemergency care	24 hours, 7 days a week, within 24 hours of request
Nonurgent sick primary care	72 hours
Nonurgent routine primary care	6 weeks
After hours, by phone	Answered by live person or call-back from a designated medical practitioner within 30 minutes
OB-GYN care for pregnant women	**Access/timeliness standard**
First trimester	14 days
Second trimester	7 days
Third trimester	3 days
High-risk pregnancy, any trimester	3 days
Family planning appointments	1 week
Specialist appointments	1 month

Access to care requirements–behavioral healthcare

Type of visit/admission/appointment	Access/timeliness standard
Scheduled appointments	Less than a 45-minute office wait
Nonurgent, routine behavioral healthcare	10 days
Urgent, nonemergency behavioral healthcare	24 hours
Care for a non-life-threatening emergency	Within 6 hours
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
Residential withdrawal management	24 hours when medically necessary
Psychiatric Residential Treatment Facility (PRTF)	20 calendar days

Access to care requirements–behavioral healthcare (cont'd)

Transitioning members will receive care even with nonparticipating providers through the following process:

- Ensures no care disruptions
- Emphasizes maintenance of member's well-being and safety while addressing needs
- May involve non-participating provider contracts
- May require authorization after 30 days

- Identifies transitioning members
- Determines needs and puts necessary services in place
- Coordinates and builds provider relationships

- Ensures member familiarity with local resources
- Considers cultural and language needs

Continuity of care–new or transferring members

When a new member actively receives medically necessary covered services from the previous MCO:

- Humana Healthy Horizons provides continuation or coordination of medically necessary covered services up to 90 calendar days after the transition date or until the member may be reasonably transferred without disruption.
- Humana Healthy Horizons may require prior authorization for continuation of service(s) beyond 30 calendar days; however, under these circumstances, authorization is not denied solely on the basis that the provider is not contracted with Humana Healthy Horizons in Louisiana.

Continuity of care during pregnancy

First trimester: Humana Healthy Horizons covers 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.

Second and third trimesters: Humana Healthy Horizons covers the costs of continued access to the prenatal care provider, regardless of the provider's contract status with Humana Healthy Horizons, for 60 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.

Humana Healthy Horizons temporarily covers continuation costs of medically necessary services covered by the previous MCO in addition to, or other than, prenatal services. After 30 days, Humana Healthy Horizons may require prior authorization for continuation of services, but authorization is not denied at that point solely based on 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.**

Care coordination support

Providers must make an effort to understand members' special needs. Daily challenges may include:

- Physical compromises
- Cognitive, behavioral, social and financial issues
- Multiple comorbidities
- Complex conditions
- Frailty
- End-of-life issues
- End-stage renal disease (ESRD)
- Isolation
- Depression
- Polypharmacy

In recognition of significant member needs, Humana Healthy Horizons incorporates person-centered care planning, coordination and treatment into our care management programs.

Care management support

- Care management is delivered within a multidisciplinary team (MDT) structure and holistically addresses the needs of each member.
- Members and authorized caregivers anchor the model-of-care core to ensure supported self-care.
- The Humana Healthy Horizons case manager coordinates the member’s MDT and collaborates closely with the member’s PCP to ensure member access to necessary medical, behavioral and other health services. PCP participation in the MDT is a critical component in successful member care.

Based on claims history and analytics, Humana Healthy Horizons' predictive model identifies potential risk levels to channel the member to the most appropriate case management program.

A comprehensive assessment is completed for each member referred to a care management program to evaluate the member’s medical, behavioral and psychosocial needs to determine the plan of care.

Member screening–behavioral health problems and disorders

PCPs are required to screen and evaluate for the detection and treatment of and referral for known or suspected behavioral health problems and disorders.

PCPs may provide clinically appropriate behavioral health services within the scope of their practices.

Louisiana Crisis Response System

Overview

LDH developed the Louisiana Crisis Response System (LA-CRS). ***The goal of the system is to prevent unnecessary hospitalizations and institutional levels by connecting the individual with trained providers to obtain the support needed to resolve the crisis and stay in the community.*** The LA-CRS services are available to members enrolled in Humana Healthy Horizons. To access the services, members and their family members can call the 24-hour behavioral health crisis line at 1-844-461-2848.

Available services

Mobile crisis response (MCR)
Initial or emergent crisis response that provides relief, resolution and intervention through crisis support and services once the triage screening has determined that MCR is the most appropriate service. Help will arrive within:

- 1 hour (if the member lives in an urban area)
- 2 hours (if the member lives in a rural environment)

Behavioral health crisis care (BHCC)
BHCC is available at walk-in centers. BHCC provides short-term, behavioral health crisis intervention at a facility that offers a community-based, voluntary, home-like alternative to a more restrictive environment.

Community brief crisis support (CBCS)
Ongoing crisis response intended to be rendered for up to 15 days (additional units may be approved with prior authorization) and designed to provide relief, resolution and intervention by:

- Maintaining the individual in the home/community
- De-escalating behavioral health needs
- Referring for treatment needs
- Coordinating additional services with local providers

Crisis stabilization (CS)
Short-term, bed-based crisis treatment and support service for individuals who have received a lower level of crisis service and are at risk of hospitalization or institutionalization, including nursing home placement.

Care management programs

Care management programs

Clinical care management programs are designed to:

- Reinforce medical providers' instructions
- Promote healthy living
- Provide guidance to members with complex conditions

To learn more, visit Humana.com/healthwellness.

Care management–initial process

Humana Healthy Horizons supports members in managing acute or chronic conditions based on acuity and member-determined outreach frequency.

- Humana identifies members through referrals from UM nurses, PCPs, specialists, member self-referral, health needs assessments, predictive model algorithms, post-discharge assessments, etc.
- Members' permission/agreement to participate is obtained. (Members may opt out at any time.)
- The care manager completes a comprehensive assessment, incorporating physical, behavioral and social determinants of health.
- The care manager helps identify key individuals of the member's multidisciplinary care team and engages the PCP.
- The care manager creates an individualized comprehensive care plan in collaboration with the member and works toward identified goals.
- The care manager coordinates care to meet identified needs and works with the member to set agreed-upon contact frequency and cadence.
- The individualized plan of care is available to providers by contacting Humana Healthy Horizons or through Availity Essentials.

Care management–ongoing

Humana Healthy Horizons case managers coordinates care for members requiring ongoing care or chronic condition management based on assigned acuity with outreach frequency determined by a member's individual needs and risk level.

- Identify triggers for emergency room (ER) visit/admission and partners with member and healthcare providers to prevent/reduce ER visits and unplanned inpatient admissions
- Address Healthcare Effectiveness Data and Information Set (HEDIS®)* measures for members' gap reports or alerts on file
- Refer to internal and external programs and community resources as needed (e.g., maternal health program, smoking cessation, food pantry resources, etc.)
- Coordinate and participate in MDT meetings to identify the best course of action for improved outcomes based on member needs
- Educate members on the disease process, self-care and value-added benefits such as dental coverage

* HEDIS is a registered trademark of the NCQA.

Chronic condition management

Examples of chronic conditions:

- Pediatric and adult asthma
- Chronic obstructive pulmonary disease (COPD)
- Cancer
- Diabetes
- Congestive heart failure
- Hypertension
- HIV/AIDS
- Substance use disorder
- Sickle cell disease
- Attention deficit hyperactivity disorder (ADHD)
- Depression and post-traumatic stress disorder (PTSD)

Goal

To help members become empowered through education and the development of self-management skills that foster treatment plan adherence and better health outcomes

Overview

- Participation is voluntary, and members may opt out at any time.
- Referral sources include claims data, UM data, health needs assessments, PCPs, self-referral, internal and external programs, LDH, OBH, other state agencies, and community partners.
- Assessment data sources include health history, cognitive/ psychological/depression screening, medication review and diet compliance.
- An MDT approach is applied.
- The case manager creates an individualized comprehensive care plan with the member and works toward identified and agreed-upon goals.
- The case manager meets frequently with the member, educating the member and involving the agreed-upon contacts on disease process, self-care and value-added benefits such as dental coverage. The case manager refers to internal and external programs and community resources as needed (e.g., maternal health program, smoking cessation, food pantry resources, etc.)

Chronic condition management (cont'd)

- Humana Healthy Horizons care managers encourage and assist members in receiving care from their PCPs.
- Care managers reinforce the provider's plan of care and facilitate the utilization of services that promote wellness and prevent unnecessary hospital admissions.
  Care managers are assigned to members based on geography and the primary health care concern driving the need for care management.
  - Humana Healthy Horizons provides registered nurses (RNs) as primary case managers for our members who have predominant physical health needs.
  - Our members who have predominant behavioral/mental health needs are connected with an LMHP as the primary case manager.
  - When those instances arise where both physical and behavioral/mental health needs exist, collaboration occurs between the RN case manager and the LMHP.

Members with special healthcare needs (SHCN)

SHCN members are individuals of any age with a behavioral health disability, physical disability, developmental disability or other circumstances that places their health and ability to fully function in society at risk, requiring individualized care approaches. Members with SHCN include, but are not limited to, all members who:

- Have complex needs, such as multiple chronic conditions, comorbidities and coexisting functional impairments
- Are at high risk for admission/readmission to a hospital within the next 6 months
- Are at high risk of institutionalization
- Have been diagnosed with a serious emotional disturbance, a severe and persistent mental illness or a substance use disorder, or otherwise have significant behavioral health needs, including those members presenting to the hospital or emergency room (ER) after a suicide attempt or nonfatal opioid, stimulant or sedative/hypnotic drug overdose
- Are homeless, as defined in Section 330(h)(5)(A) of the Public Health Service Act and codified by the Department of Health and Human Services in 42 U.S.C. 254(b)

Members with SHCN (cont'd)

- Are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors) or who had an adverse outcome during the pregnancy, including preterm birth of less than 37 weeks
- Were recently incarcerated and are transitioning out of custody
- Are at high risk of inpatient admission or emergency room (ER) visits, including certain members transitioning care across acute, chronic disease and rehabilitation hospitals or nursing facility settings
- Are members of the DOJ agreement—target population
- Are enrolled under the Act 421 Children's Medicaid Option
- Receive care from other state agency programs, including programs through the Office of Juvenile Justice (OJJ), Department of Children & Family Services (DCFS) or OPH

Maternal health and transition programs

HumanaBeginnings®

- Manages prenatal and postpartum members from onset of pregnancy up to 8 weeks postpartum
- Facilitates care coordination with the federal supplemental nutrition program for women, infants and children, known as WIC, Healthy Start, and other internal or external programs

Transition program

- Provides support for members as they transition out of inpatient care to the community
- Supports follow-up appointments with PCP and specialists, including an assessment of transportation needs
- Ensures delivery of at-home, post-discharge items, such as durable medical equipment (DME), medication or home health services
- Reviews discharge instructions and changes to medication

Population health and incentive programs

Member incentive programs

Breast cancer screening (40 and older)

Cervical cancer screening (21 and older)

Colorectal cancer screening (45 and older)

COVID-19 vaccine

Diabetic screening (18 and older)

Diabetic retinal eye exam (18 and older)

Annual wellness visits (3 and older)

Smoking cessation (12 and older)

Weight management (12 and older)

Health needs assessment

Prenatal, postpartum and well-baby visits

Annual flu shot

- Healthy behavior programs are designed to help members live a healthier lifestyle and maintain health.
- Members can call Humana Healthy Horizons for program specifics and to join a program.
- PCPs may be asked to provide program goals and accomplishments.
- Members can earn rewards.

Member referral

Providers can refer members to care management programs by contacting Humana Healthy Horizons.

- Call Member Services: 1-800-448-3810.
- Send an email to LAMCDCaseManagement@humana.com.
- Fax or email a completed Care Management Referral Form.

Claims submission and processing

Electronic claim submission–claims clearinghouses*

Availity Essentials is Humana's preferred claims clearinghouse; however, providers can use other clearinghouses if they can submit to Availity Essentials. The following list contains some of the frequently used clearinghouses.

* Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

Resources:

- Go to Humana.com/ClaimResources.
- Choose "Claims and encounter submission," then "Electronic Claims Submission."

Availity Essentials	Availity.com
Change Healthcare	ChangeHealthcare.com
TriZetto	TriZettoProvider.com
McKesson	McKesson.com
SSI Group	TheSSIGroup.com

Electronic claim submission–payer IDs

When filing an electronic claim, you need to utilize one of the following payer IDs:

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

Questions?
Call Provider Services at 1-800-448-3810.

Paper claim submission

Paper claims for medical and behavioral health services should be submitted to the address listed on the back of the member's ID card or to the appropriate address listed below:

Claims

Humana Claims Office

P.O. Box 14601

Lexington, KY 40512-4822

Encounters

Humana Claims Office

P.O. Box 14605

Lexington, KY 40512-4605

Importance of Medicaid encounter submissions

LDH requires submissions for all paid or denied service encounters

- Includes services paid at $0
- Includes fee-for-service and capitated providers
- Necessitates appropriate provider registration and documentation

Encounter tracking identifies members who've received services and:

- Decreases the need for medical record review during HEDIS
- Is critical for the future world of Medicaid risk adjustment
- Helps identify members receiving preventive screenings and decreases members listed in gaps-in-care reports

Claims submissions and processing–avoiding submission errors

Common rejection or denial reasons:

- Submission of an incorrect NPI/ZIP code/taxonomy code (Note: NPI, taxonomy code and ZIP+4 are referred to as the NPI Crosswalk.)
- Missing NPI/ZIP code/taxonomy code
- Submissions that show a billing and/or rendering NPI that is not enrolled or registered for Medicaid with LDH
- Submission encounters showing $0 billed charges

How to avoid submission errors:

- Confirm submitted information exactly matches the provider information registered with LDH (NPI, Medicaid number, taxonomy code, ZIP+4, provider specialty code, provider type code) and is in accordance with the services provided.
- Ensure billing and rendering NPIs listed on the claim are accurate and are enrolled/registered for Medicaid with LDH.
- Ensure billed amounts are greater than $0. (Providers must submit billed charges.)

Claims submissions and processing–avoiding submission errors (cont'd)

Common member-related rejection or denial reasons:

- Member not found
- Insured member not found
- Invalid Healthcare Common Procedure Coding System (HCPCS) code submitted
- No authorization or referral found
- Missing billed amount
- National Drug Code not covered or invalid
- Billing/rendering NPIs not enrolled/registered for Medicaid with LDH

How to avoid these errors:

- Confirm submitted patient information is accurate and correct
- Ensure all required claim form fields are complete and accurate
- Obtain proper authorizations and/or referrals for services rendered
- Ensure billed amounts are greater than $0
- Ensure submitted claims include a valid Medicaid ID for the billing/rendering NPIs

Timely filing

- Claims should be filed as soon as possible, no later than 365 calendar days from the date of service.
- Providers involving third-party liability (excluding Medicare) should file as soon as possible, within 365 calendar days from the date of service.
- When Medicare is the primary insurer, providers must file the claim within 180 calendar days from Medicare's Explanation of Benefits (EOB) of payment or denial.
- Providers are required to file claims in a timely manner for encounters for all services rendered to members.
- Timely filing is an essential component reflected in Humana's HEDIS reporting and ultimately can affect how a provider's plans are measured in member preventive care and screening compliance.
- Visit Humana.com/MakingItEasier for more information on claims and payment processes.

Coordination of benefits (COB)–crossover claims

If a member has:

- Traditional Medicare—file directly to Medicare and claims will cross over to Humana Healthy Horizons to consider for secondary payment.
- Part C Medicare plan or a commercial medical plan—submit claims to the primary carrier first and then file with Humana with the EOB from the primary payer(s) to be considered for secondary payment.

Claims dispute management—reconsideration

Claim reconsideration (first level): Providers have 180 days from the denial of the claim to submit a reconsideration request. A determination will be made within 30 days of Humana's receipt of the request.

Option 1:	Call Provider Services at 1-800-448-3810. Have claim reference number ready.
Option 2:	Submit claim reconsideration requests to the following address: Humana Healthy Horizons in Louisiana Attn: Claim Reconsiderations and Appeal P.O. Box 14601 Lexington, KY 40512-4601
Option 3:	Submit claim reconsideration requests through Availity Essentials.

Claims dispute management—appeal

Claim appeals (second level): Claim appeal requests must be submitted in writing.

Submit formal claim appeals to:

Humana Healthy Horizons of Louisiana
Attn: Claim Reconsiderations and Appeals
PO Box 14601
Lexington, KY 40512-4601

Claims payment—electronic funds transfer (EFT) and electronic remittance advice (ERA)

Receive Humana Healthy Horizons payments via direct deposit into the bank account of your choice.

Receive ERA transactions that are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Get paid up to 7 days faster than via postal mail.

Have remittances sent to your clearinghouse or view them online.

Reduce the risk of lost or stolen checks.

Reduce paper mail and time spent on manual processes.

E-business resources

Contact us if your organization needs:

 Payments deposited in **more than one bank account**

 **Separate remittance information** for different providers or facilities

 ERA/EFT setup for **multiple provider groups, facilities and/or individuals**

An e-business consultant can help set up ERA and EFT quickly and accurately.

Call Provider Services for assistance at 1-800-448-3810.

Balance billing

The provider agrees that if Humana denies payment for member services due to a lack of medical necessity, the provider shall not bill, charge, seek payment nor have any recourse against the member for such services.

- Notwithstanding the approved cost-sharing obligation, the provider agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, or reimbursement from, or have recourse against, members for covered services that are rendered to the member.

- Visit Humana.com/MakingItEasier for more information on claims and payment processes.

Value-based payment

Value-based payment (VBP) program overview

Humana Healthy Horizons is committed to fostering high-value care in the communities we serve. We developed value-based 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 provides practice coaching and quality improvement support to facilitate participation and advancement in these programs. Program terms and metrics are reviewed annually and modified as appropriate. All earned performance-based payments are made in arrears to allow for reporting and data collection.

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

Humana Healthy Horizons

PCP quality recognition programs

Louisiana

Medicaid quality recognition

Annual incentive paid to provider practices for achieving quality measures

Program highlights

- Practices are eligible for an incentive based on achieving targets for a subset of measures.
- **Adult** and **pediatric** membership categories are measured separately.
- Program measures are updated annually within each category.

Requirements

- Practices must be contracted for the Medicaid line of business.
- Meet and maintain a membership threshold of 30 paneled patients in adult and/or pediatric categories at the beginning and end of the measurement year.

Model practice

Quarterly incentives paid to provider practices for achieving individual quality, clinical and strategic measures*

Program highlights

- Practices can earn a per-member, per-month **(PMPM)** incentive per target achieved.
- The program provides opportunity for shared savings.
- **Adult** and **pediatric** membership categories are measured separately.
- Program measures are updated annually within each category.

Requirements

- Sign a value-based contract to participate.
- Meet a membership threshold of 250 paneled patients; 125-member threshold is required for adult and/or pediatric category eligibility.

Medical home

Quarterly incentive paid to provider practices for achieving quality, clinical and strategic measures*

Program highlights

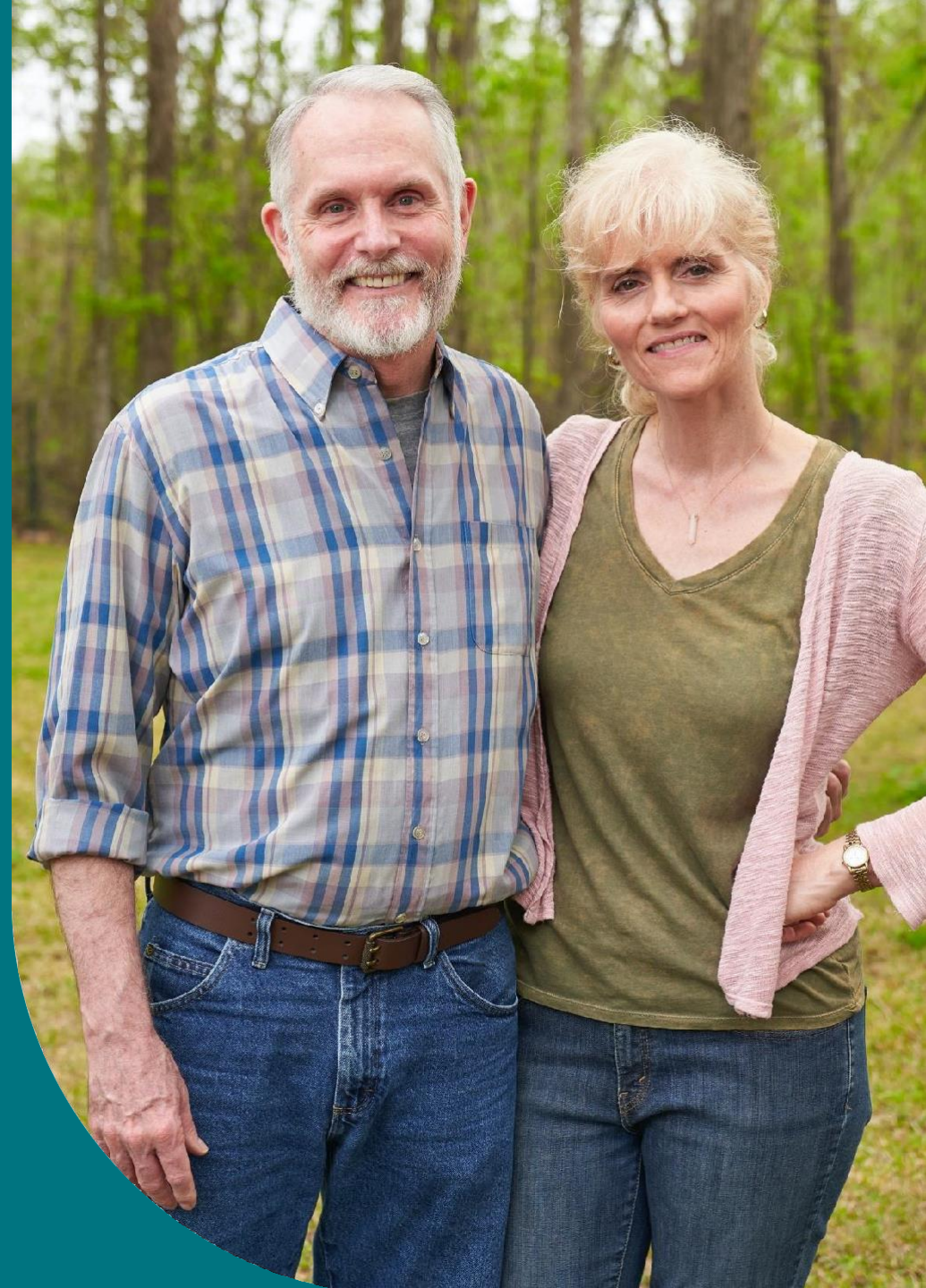
- Practices can earn a PMPM incentive per target achieved and are eligible to receive a monthly incentive payment.
- The program provides opportunity for shared savings.
- **Adult** and **pediatric** membership categories are measured separately.
- Program measures are updated annually within each category.

Requirements

- Sign a value-based contract to participate and have a location recognized as a patient-centered medical home.
- Meet a membership threshold of 250 paneled patients; 125-member threshold is required for adult and/or pediatric category eligibility.

* Medicaid PCP quality recognition payments will be paid annually in year 1.

Medicaid risk adjustment



Louisiana Medicaid and Medicaid risk adjustment (MRA)

LDH uses the Chronic Illness and Disability Payment System (CDPS + Rx) to develop risk adjustment scores. The relative costs were developed using Louisiana-specific historical data from Medicaid fee-for-service (FFS) claims and encounter data. LDH intends to update the MCO risk scores semiannually.

To ensure budget neutrality for annual LDH Medicaid expenditures, the relevant portions of each MCO's proposed base capitation rates are adjusted based on the MCO's risk score that reflects the expected healthcare expenditures associated with its members relative to the applicable total Medicaid population.

CDPS +Rx hierarchies and comorbidities

- CDPS categories are hierarchical within each major category.
- Weights/cofactors are additive across major categories.
- Within major categories, only the most severe diagnosis counts.
- CDPS categories allow an accounting of comorbidities across medical and pharmacy.

When it comes to coding comorbidities, for which Medicaid allows up to 12 diagnosis codes on electronic forms, please consider the following:

- The diagnosis shown in the record to be chiefly responsible for the services delivered should be coded first.
- All documented conditions that coexist and require or affect patient care, treatment or management should be coded.

Best documentation practices for diagnosis coding

Legible

- Makes entire medical record legible to all objective readers of the record

Clear

- Communicates the document's intent to all readers

Concise

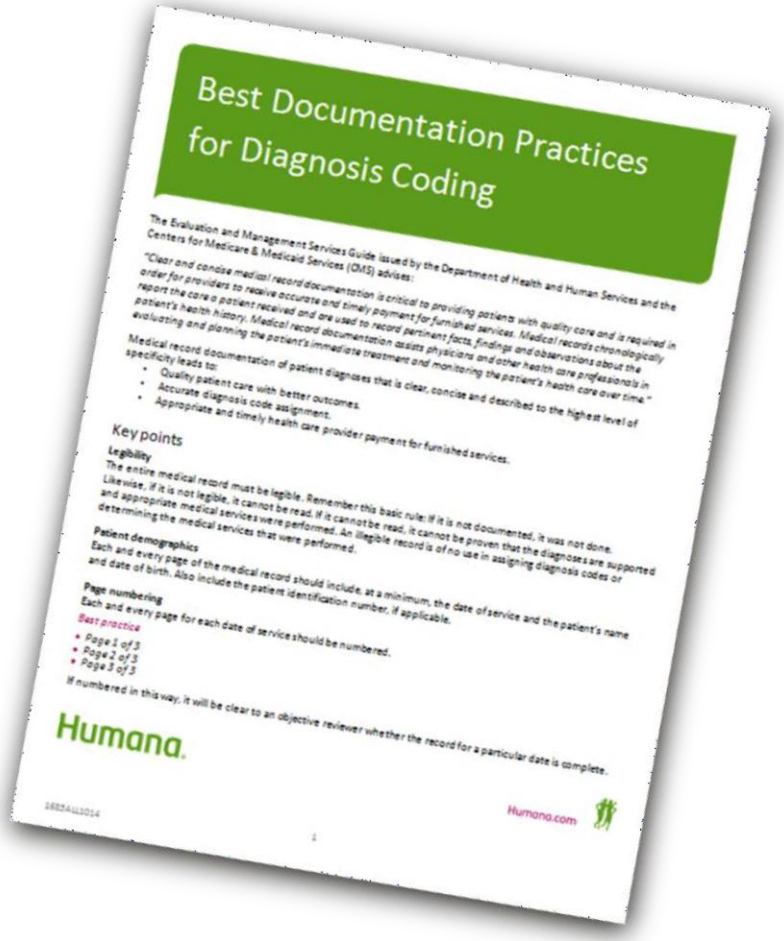
- Describes each diagnosis succinctly and to the highest level of specificity
- Limits or avoids altogether the use of abbreviations

Consistent

- Avoids conflicts or contradictions

Complete

- Includes documentation of all conditions evaluated and treated, as well as all chronic or other conditions that affect patient care, treatment or management
- Includes date of service, patient name and date of birth on each page
- Includes healthcare provider name, credentials and signature


Best Documentation Practices for Diagnosis Coding

The Evaluation and Management Services Guide issued by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) advises:

"Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings and observations about the patient's health history. Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring the patient's health care over time."

Medical record documentation of patient diagnoses that is clear, concise and described to the highest level of specificity leads to:

- Quality patient care with better outcomes
- Accurate diagnosis code assignment
- Appropriate and timely health care provider payment for furnished services.

Key points

Legibility

The entire medical record must be legible. Remember this basic rule: If it is not documented, it was not done. Likewise, if it is not legible, it cannot be read. If it cannot be read, it cannot be proven that the diagnoses are supported and appropriate medical services were performed. An illegible record is of no use in assigning diagnosis codes or determining the medical services that were performed.

Patient demographics

Each and every page of the medical record should include, at a minimum, the date of service and the patient's name and date of birth. Also include the patient identification number, if applicable.

Page numbering

Each and every page for each date of service should be numbered.

Best practice

- Page 1 of 3
- Page 2 of 3
- Page 3 of 3

If numbered in this way, it will be clear to an objective reviewer whether the record for a particular date is complete.

Humana.

Humana.com

Clinical coding example

Excerpt from full medical record

History of present illness: 49-year-old homeless diabetic male complains of right ankle wound. He lost his balance while coming downstairs at a facility. Unable to check blood sugars given his living situation, but told it was uncontrolled at last clinic visit a few months ago. He admits to noncompliance with his diabetic diet as he eats what's given to him. Sometimes he feels pins and needles sensation in his feet.

Physical exam:

- General: No acute distress, ambulating without assistance.
- Head, eye, ears, nose and throat (HEENT) assessment: No abnormalities noted.
- Heart: Regular rate and rhythm with no murmurs, rubs or gallops.
- Lungs: Clear bilaterally.
- Abdomen: Soft non-tender with good bowel sounds, no masses or bruits.
- Extremities: No clubbing or cyanosis, normal range of motion, right ankle 1+ edema; pedal pulses 1+.
- Neuro: Alert and oriented, ankle and knee DTR 1+/4, positive monofilament exam on plantar and dorsal surface of right foot, negative Romberg, steady gait.
- Skin: Warm and dry, tender erythematous 1 cm superficial ulceration noted right medial malleolus, but no discharge.

Clinical coding example (cont'd)

Assessment:

- Diabetes mellitus, type 2, uncontrolled with hyperglycemia
- Diabetic ulcer right ankle involving skin only
- Diabetic peripheral neuropathy

Plan:

Keep wound clean and dry

- Follow-up visit in 10 to 14 days
- Prescription given for Keflex 500 mg by mouth twice daily for 10 days
- Over-the-counter (OTC) Tylenol for pain as directed
- X-ray right ankle
- Sent to lab for CBC, CMP, TSH, HbA1c, random urine albumin, urine albumin creatinine ratio
- Diabetic teaching with nutrition consult for diabetic diet

Example coded as:

Incomplete coding

E11.9	Type 2 diabetes mellitus without complications
S91. ØØ1A	Unspecified open wound, right ankle, initial encounter
G62.9	Polyneuropathy, unspecified

Complete coding

E11.622	Type 2 diabetes with other skin ulcer
L97.311	Non-pressure chronic ulcer of right ankle limited to breakdown of skin
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.65	Type 2 diabetes mellitus with hyperglycemia
J59.10	Inadequate housing

Submitting corrected claims

Healthcare providers can submit corrected claims at Availity Essentials.

Correcting electronic claims:

Professional 837P ASC X12 format: Loop 2300	Institutional 837P ASC X12 format: Loop 2300
Segment: CLM • CLM01 (claim submitter's identifier) • CLM02 (monetary amount) • CLM05 (healthcare service location information) – CLM05 – 1 (facility code value) – CLM05 – 2 (facility code qualifier) – CLM05 – 3 (claim frequency type code) • CLM06 (yes/no condition or response code) • CLM07 (provider accepts assignment code) • CLM08 (yes/no condition or response code) • CLM09 (release of information code)	Segment: CLM ▪ CLM01 (claim submitter's identifier) ▪ CLM02 (monetary amount) ▪ CLM05 (healthcare service location information) – CLM05 – 1 (facility code value) – CLM05 – 2 (facility code qualifier) – CLM05 – 3 (claim frequency type code) ▪ CLM07 (provider accepts assignment code) ▪ CLM08 (yes/no condition or response code) ▪ CLM09 (release of information code)

Correcting paper claims:

- Professional claims: CMS 1500 – Stamp "Corrected Billing" on the CMS 1500 form.
- Institutional claims: UB-04 – Submit with the third digit of type of bill as "7" to indicate frequency code.

Medicaid risk adjustment–electronic health records (EHRs)

Advantages:

- EHRs and the ability to exchange health information electronically can help you provide higher quality and safer care for patients while creating tangible organization enhancements. EHRs help providers better manage patient healthcare.
- EHRs provide **accurate, up-to-date and complete information about patients** at the point of care.
- EHRs enable quick access to patient records for more **coordinated, efficient care**.[1]
- EHRs securely **share electronic patient information** with other clinicians.
- EHRs help providers more effectively **diagnose patients, reduce medical errors and provide safer care**.[2]

1. "Improve Care Coordination," HealthIT.gov, last accessed Nov. 15, 2023, https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/improve-care-coordination.

2. "Improved Diagnostics and Patient Outcomes," HealthIT.gov, last accessed Nov. 15, 2023, https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/improved-diagnostics-patient-outcomes.

LDH provider-based marketing guidelines

LDH provider-based marketing guidelines

- No marketing materials shall be disseminated through Humana Healthy Horizons' provider network.
- Providers shall not solicit enrollment or disenrollment in an MCO or distribute MCO-specific materials as a marketing activity.

Providers may:

- Inform patients of and identify all contracted provider MCO affiliations
- Display and/or distribute health education materials for all contracted MCOs or choose not to display and/or distribute for any contracted MCOs.

Health education materials shall adhere to the following guidance:*

- Posters cannot be larger than 16 by 24 inches.
- MCO-donated children's books must be located 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 each MCO with which they contract.

Providers may display MCO marketing materials, provided that appropriate notice is conspicuously and equitably posted, and marketing of all provider-contracted MCOs are equally displayed.

NOTE: The above information was extracted directly from LDH contractual requirements.

* Materials must be reviewed/approved by the plan and submitted to LDH for approval, as necessary, before distributing.

LDH provider-based marketing guidelines (cont'd)

- Providers may display MCO participation stickers only if stickers for all contracted MCOs are displayed.*
- MCO stickers indicating provider contract participation cannot be larger than 5 by 7 inches. The stickers must display ONLY the MCO name and/or logo or with the statement that it is accepted or welcomed at the facility.
- Providers may inform their patients of the benefits, services and specialty care services offered through contracted 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 attempt to influence a member's decision.

On actual termination of an MCO contract, a provider who has contracts with other MCOs may notify patients of the change in status, contract termination date and the patient impact of such a change. Providers shall continue to see current patients enrolled in the MCO until the contract is terminated according to all terms and conditions specified in the contract between the provider and the MCO.

NOTE: The above information was extracted directly from LDH contractual requirements.
* Materials must be reviewed/approved by the plan and submitted to LDH for approval, as necessary, before distributing.

Additional training requirements

Additional training requirements

Providers must complete additional annual required compliance training on the following topics:

- General compliance and fraud, waste and abuse
- Cultural competency
- Health, safety and welfare (abuse, neglect and exploitation)
- Others as required

This training is located on the following secure provider websites: Humana.com/ProviderCompliance and Availity Essentials.

Be sure to complete the Medicaid Partner Training Attestation form to ensure completion is documented.

Fraud, waste and abuse

Fraud, waste and abuse–reporting requirements and options

Providers suspecting or detecting a fraud, waste and abuse (FWA) violation must report it either to Humana or their respective organization, which must then inform Humana of the violation.

Telephone:

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

Email: SIUReferrals@humana.com

or ethics@humana.com

Web: Ethics Helpline

Fax: 1-920-339-3613

All information will be kept confidential.

Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Also, Humana has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

FWA–reporting information (cont'd)

There are several ways you can alert LDH for investigation and possible swift punishment:
By phone –

- Provider fraud complaints: 1-800-488-2917
- Recipient (member) fraud complaints: 1-833-920-1773

Complete the appropriate form below and submit it electronically.

- Provider Fraud Form
- Recipient (Member) Fraud Form

Submit your **provider** fraud complaint by mail to:
Gainwell
SURS Department
8591 United Plaza Blvd.
Baton Rouge, LA 70809

Fax **provider** fraud complaints to
1-225-216-6129.

Submit your **recipient (member)** fraud complaint by mail to:
Customer Service Unit
Louisiana Department of Health
P.O. Box 91278
Baton Rouge, LA 70821-9278

Fax **recipient** fraud complaints to
1-225-389-2610.

False Claims Act

Disallowed actions (31 U.S.C. §§ 3729-3733)
Links to the above provisions of this act are listed within Humana's Compliance Policy for Contracted Healthcare Providers and Business Partners, which is available at Humana.com/fraud.

The False Claims Act permits a person with knowledge of fraud against the U.S. government to file a lawsuit (plaintiff) on behalf of the government against the person or business that committed the fraud (defendant).

Individuals who file such suits are known as "whistleblowers." If the action is successful, the plaintiff is rewarded with a percentage of the recovery. Retaliation against individuals for investigating, filing or participating in a whistleblower action is prohibited.

Liability (31 U.S.C. 3729(a)(1) and (a)(3)):
Liability for the foregoing acts includes:

- A civil penalty of $5,000–10,000;
- 3 times the amount of damages, which the government sustains because of that act

A person/company that violates the False Claims Act also is liable to the government.

Adverse incident reporting

Adverse incident reporting

Humana's risk management program includes a critical and adverse incident reporting and management system for critical events that negatively impact the health, safety and welfare of our members.

- If the member is in immediate danger, call 911 or local police.
- Call Member/Provider Services at 1-800-448-3810.
- Online reporting is through the "New Incident" tab on Quickbase.
- The following incident types can be reported: abuse, exploitation, neglect, death from abuse and death.
- Report to the appropriate agencies such as Department of Children and Family Services (DCFS), Adult Protective Services (APS), Elderly Protective Services and/or Department of Health Facility Complaints.
  - Louisiana Department of Child Protective Services: 1-855-452-5437
  - Louisiana Adult Protective Services, vulnerable adults 18–59: 1-800-898-4910
  - Louisiana Elderly Protective Services, adults 60 and older: 1-833-577-6532
  - LDH Facility Complaints
  - Humana Healthy Horizons has the right to take corrective action as needed to ensure its staff, participating providers and direct service providers comply with the critical incident reporting requirements.

Humana online resources and phone numbers

Provider website–public

Humana.com/providers and
Humana.com/HealthyLA

- Health and wellness programs
- Clinical practice guidelines
- Provider publications (including provider handbook)
- Pharmacy services
- Claim resources
- Quality resources
- What's new?

For questions and assistance with **Humana.com** sites, call Provider Services at 1-800-448-3810.

Working with Humana online? Use the multipayer provider portal

The provider portal Availity Essentials is the preferred method for online transactions.

- ✓ Use one site to work with Humana and other payers.
- ✓ Check eligibility and benefits.
- ✓ Submit referrals and authorizations.
- ✓ Manage claim status.
- ✓ Use Humana-specific tools.
- ✓ Submit grievances.

To register:
Visit Availity Essentials.

Need training?
Visit Humana.com/ProviderWebinars to learn about training opportunities and reserve your class space.

About Availity

- Cofounded by Humana
- Humana's clearinghouse for electronic data interchange (EDI) transactions with providers

Helpful numbers

- **Medicaid Member/Provider Services:** 1-800-448-3810, Monday through Friday, 7 a.m. to 7 p.m.
- **Clinical Intake Team (CIT) for medical procedures:** 1-800-448-3810, Monday through Friday, 7 a.m. to 7 p.m.
- **Prior authorization for medication billed as medical claim:** 1-866-461-7273, Monday through Friday, 7 a.m. to 5 p.m.
- **Prior authorization for pharmacy drugs:** 1-800-424-1664, 24 hours a day, 7 days a week
- **Pharmacist prescription inquiries:** 1-800-424-1664, 24 hours a day, 7 days a week
- **24-hour nurse hotline:** 1-800-448-3810
- **24-hour behavioral health crisis line:** 1-844-461-2848
- **Medicaid care management:** 1-800-448-3810

Helpful numbers (cont'd)

- **Availity customer service/tech support:** 1-800-282-4548
- **Ethics and compliance concerns:** 1-877-5-THE-KEY (584-3539)
- **Reporting Medicaid fraud:** 1-800-488-2917
- **Questions about arranging interpretation services for member appointments:** 1-877-320-1235

Local provider relations team

Humana has a team of dedicated Provider Relations representatives who are regionally aligned by each of the Medicaid regions. This team can assist with:

- On-site visits
- Provider education and training
- Unresolved escalated issues

To request a visit, email: LAMedicaidProviderRelations@humana.com

Humana

Healthy Horizons.

in Louisiana