HUMANA

ANCILLARY PARTICIPATION AGREEMENT

State: Louisiana

COVER SHEET

Creation Date:	
Icertis Contract Number:	MERLIN ID:
Provider Name: Legal Name: DBA Name:	

Federal Tax ID: EIN:

Optional Information:	
NPI:	Provider Specialty:

Contract Contact Information: Name:

Address Line 1:	
Address Line 2:	
City:	State: Zip:
Phone: Ext :	Fax:
Email:	

Address for Notice Name:

Address Line 1:	
Address Line 2:	
City:	State: Zip:
Phone: Ext :	Fax:
Email:	

Contractor Information: Name:	
Address Line 1:	
Address Line 2:	
City:	State: Zip:
Phone: Ext	Fax:
Email:	

ANCILLARY PARTICIPATION AGREEMENT

This **Ancillary** Participation Agreement ("**Agreement**") is made and entered into by and between the party named on the signature page below (hereinafter referred to as **"Provider"**) and Humana Health Benefit Plan of Louisiana, Inc. and their affiliates that underwrite or administer health plans (hereinafter referred to as "**Humana**").

1. RELATIONSHIP OF THE PARTIES

1.1 In performance of their respective duties and obligations hereunder, **Humana** and **Provider**, and their respective employees and agents, are at all times acting and performing as independent contractors, and neither party, nor their respective employees and agents, shall be considered the partner, agent, servant, employee of, or joint venture with, the other party. Unless otherwise agreed to herein, the parties acknowledge and agree that neither **Provider** nor **Humana** will be liable for the activities of the other nor the agents and employees of the other, including but not limited to, any liabilities, losses, damages, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or governmental authority arising out of or in connection with: (i) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (ii) any negligent act or omission or other misconduct; (iii) the failure to comply with any applicable laws, rules or regulations; or (iv) any accident, injury or damage to persons or property. Notwithstanding anything to the contrary contained herein, **Provider** further agrees to and hereby does indemnify, defend and hold harmless **Humana** from any and all claims, judgments, costs, liabilities, damages and expenses whatsoever, including reasonable attorneys' fees, arising from any acts or omissions in the provision by **Provider** of Covered Services to Members. This provision shall survive termination or expiration of this Agreement.

1.2 The parties agree that **Humana's** affiliates whose Members receive services hereunder do not assume joint responsibility or liability between or among such affiliates for the acts or omissions of such other affiliates.

2. SERVICES TO MEMBERS

2.1 Subject at all times to the terms of this Agreement, **Provider** agrees to provide or arrange for services which are benefits payable under Humana's Louisiana Medicaid plan ("hereinafter referred to as "Covered Services) to individuals designated by **Humana** (herein referred to as "Members") with certain health benefits (herineafter referred to as "Plan" or "Plans") with an identification card or other means of identifying them as Members to which **Provider** has agreed to participate as set forth in the product participation list attachment.

3. THIRD PARTY BENEFICIARIES

3.1 Except as is otherwise specifically provided in this Agreement, the parties have not created and do not intend to create by this Agreement any rights in other parties as third-party beneficiaries of this Agreement, including, without limitation, Members.

4. SCOPE OF AGREEMENT

4.1 This Agreement sets forth the rights, responsibilities, terms and conditions governing: (i) the status of **Provider** and **Provider's** employees, subcontractors and/or independent contractors as health care providers (hereinafter referred to as "**Participating Providers**") providing Covered Services; and (ii) **Provider's** provision of Covered Services (hereinafter referred to as "**Provider Services**") to Members. All terms and conditions of this Agreement which are applicable to "**Provider**" are equally applicable to each Participating Provider, unless the context requires otherwise.

4.2 **Provider** represents and warrants that it is authorized to negotiate terms and conditions of provider agreements, including this Agreement, and further to execute such agreements for and on behalf of itself and its Participating Providers. **Provider** further represents and warrants that Participating Providers will abide by the terms and conditions of this Agreement, including each of **Providers**

employed, subcontracted or independently contracted physicians in the event **Provider** is organized and providing services hereunder as a group practice. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between **Provider** and Members regarding the Members' medical conditions or treatment options, and **Provider** acknowledges that all patient care and related decisions are the sole responsibility of **Provider** and **Humana** does not dictate or control clinical decisions with respect to the medical care or treatment of Members.

4.3 **Provider** shall comply with all applicable contract requirements, applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and subregulatory guidance.

5. SUBCONTRACTING PERFORMANCE

5.1 **Provider** shall provide directly, or through appropriate agreements with providers and other licensed health care professionals and/or providers, Provider Services for Members. It is understood and agreed that **Provider** shall maintain written agreements with Participating Providers in a form comparable to, and consistent with, the terms and conditions established in this Agreement. **Provider's** downstream provider agreements shall include terms and conditions which comply with all applicable requirements for provider agreements as required by the Louisiana Department of Health ("LDH") and any applicable state and federal laws, rules and regulations. In the event of a conflict between the language of the downstream provider agreements and this Agreement, the language in this Agreement shall control.

6. ACQUISITIONS

6.1 This Section applies to any **Provider** acquisition through any means including, but not limited to, asset or stock purchase, merger, or consolidation (collectively, "**Acquisition**") of an ownership interest in a facility or other provider of whatever type or construction including, but not limited to, a (i) hospital, (ii) free standing ambulatory surgery center, (iii) radiology center, (iv) sleep center; or (v) physician, physician group, Independent Practice Association or Physician Hospital Organization (collectively, "**Entity**"). In the event of **Provider's** Acquisition of an Entity and such Entity has an agreement in effect with **Humana** for the provision of Covered Services, then such Entity shall not become a participating provider with **Humana** under this Agreement but, rather, the existing separate agreement between **Humana** and such Entity will control for its duration. Furthermore, **Provider** shall not exercise any termination or nonrenewal right which may exist in the agreement between **Humana** and such Entity for a period of twelve (12) months subsequent to the effective date **Provider** acquires its ownership interest in such Entity.

6.2 In the event **Provider's** ownership, separate existence or entity construction (e.g., corporation, limited liability company, etc.) is altered or affected in any way as a result of acquisition, merger, consolidation or through any other means whatsoever (including, but not limited to, being merged into an affiliated entity), then this Agreement shall continue to control with respect to **Provider's** provision of Covered Services to **Humana's** Members notwithstanding any contrary outcome which may otherwise be allowed or required by law. Furthermore, **Provider** agrees that it shall not exercise any termination or nonrenewal right which may otherwise exist in this Agreement for a period of twelve (12) months subsequent to the effective date of such transaction event.

7. TERM AND TERMINATION

7.1 This term of this Agreement shall commence on the date **Humana** inserts in this Agreement (the "Effective Date"). **Humana** has full authority to determine the Effective Date according to **Humana's** processing and/or credentialing requirements. The Initial Term of this Agreement shall be for Three (3) years ("Initial Term"). After the Initial Term, this Agreement shall automatically renew for subsequent one (1) year terms unless either party provides written notice of non-renewal to the other party at least ninety (90) days prior to the end of the initial term or any subsequent renewal terms.

7.2 Notwithstanding anything to the contrary herein, after the Initial Term, either party may terminate this Agreement without cause by providing to the other party one hundred twenty (120) days prior written notice of termination.

7.3 **Humana** may terminate this Agreement, or any individual Participating Provider, immediately upon written notice to **Provider**, stating the cause for such termination, in the event: (i) **Provider's** or any individual Participating Provider's, continued participation under this Agreement may adversely affect the health, safety or welfare of any Member or brings **Humana** or its health care networks into disrepute; (ii) **Provider** or any individual Participating Provider fails to meet **Humana's** credentialing or re-credentialing criteria; (iii) **Provider** or any individual Participating Provider is excluded from participation in any federal health care program; (iv) **Provider** or any individual Participating Provider voluntarily or involuntarily seeks protection from creditors through bankruptcy proceedings or engages in or acquiesces to receivership or assignment of accounts for the benefit of creditors; or (v) **Humana** loses its authority to do business in total or as to any limited segment of business, but then only as to that segment.

7.4 In the event of a breach of this Agreement by either party, the non-breaching party may terminate this Agreement upon at least sixty (60) days prior written notice to the breaching party, which notice shall specify in detail the nature of the alleged breach; provided, however, that if the alleged breach is susceptible to cure, the breaching party shall have thirty (30) days from the date of receipt of notice of termination to cure such breach, and if such breach is cured, then the notice of termination shall be void of and of no effect. If the breach is not cured within the thirty (30) day period, then the date of termination shall be that date set forth in the notice of termination. Notwithstanding the foregoing, any breach related to credentialing or re-credentialing, quality assurance issues or alleged breach regarding termination by **Humana** in the event that **Humana** determines that continued participation under this Agreement may affect adversely the health, safety or welfare of any Member or bring **Humana** or its health care networks into disrepute, shall not be subject to cure and shall be cause for immediate termination upon written notice to **Provider**.

7.5 **Provider** agrees that the notice of termination or expiration of this Agreement shall not relieve **Provider** of its obligation to provide or arrange for the provision of Provider Services through the effective date of termination or expiration of this Agreement.

8. POLICIES AND PROCEDURES

8.1 **Provider** agrees to comply with **Humana's** quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by **Humana** from time to time and, in addition, those policies and procedures which are set forth in **Humana's** Louisiana Medicaid Provider Manual, or its successor (hereinafter referred to as the "Manual"), and bulletins or other written materials that may be promulgated by **Humana** from time to time to supplement the Manual. The Manual and updated policies and procedures may be issued and distributed by **Humana** in electronic format. Revisions to such policies and procedures shall become binding in accordance with La. R.S. 6:460

8.2 **Provider** agrees to work in collaboration to actively improve the quality of care provided to Members, consistent with the applicable quality improvement goals and quality measures.

8.3 **Provider** agrees to **Humana** shall be permitted to conduct on-site visits for quality management and quality improvement purposes upon reasonable notice to **Provider**.

8.4 **Humana** shall maintain an authorization procedure for **Provider** to verify coverage of Members under a **Humana** Louisiana Medicaid plan.

8.5 Notwithstanding anything to the contrary in this Agreement or in the Member's health benefits contract, **Provider** shall obtain authorization from **Humana** prior to the provision of those services for which **Humana** requires prior authorization. Prior to rendering any non-emergent service, **Provider** is responsible for determining if such service requires prior authorization by reviewing **Humana's** prior authorization requirements posted on http://www.humana.com/providers/ (or any subsequent location as may be specified in the Manual or otherwise by written notice) or by

contacting **Humana's** customer service phone number, as indicated on Member's identification card.

9. CREDENTIALING AND PROFESSIONAL LIABILITY INSURANCE

9.1 Participation under this Agreement by **Provider** and Participating Providers is subject to the satisfaction of all applicable credentialing and re-credentialing standards established by **Humana** and **LDH**. **Provider** shall provide **Humana**, or its designee, or LDH's Credentials Verification Organization ("CVO") information necessary to ensure compliance with such standards at no cost to **Humana** or its designee or CVO. **Provider** agrees to use electronic credentialing and recredentialing processes when administratively feasible. **Provider**, as applicable, and all Participating Providers providing Covered Services to **Humana** Members shall be credentialed in accordance with **Humana,** LDH or CVO's credentialing process(es) prior to receiving participating status with **Humana**.

9.2 **Provider** shall at all times when performing services for Members be enrolled in the Louisiana Medicaid Program. **Provider** shall notify **Humana** immediately should the **Provider** at any time hereunder be disenrolled in the Louisiana Medicaid Program. Any payments made by **Humana** to **Provider** for services to Members when the **Provider** was not enrolled in the Louisiana Medicaid Program shall be returned in full to **Humana**.

9.3 **Provider** warrants that it has a valid National Provider identifier (NPI) Number, where applicable, has a valid license or certification to perform services in Louisiana, has not been excluded or barred from participation in Medicare, Medicaid, Children's Health Insurance Program created in 1997 by Title XXI of the Social Security Act, known in Louisiana as LaCHIP ("CHIP"), and/or any other government healthcare program and has obtained a Medicaid provider number from LDH.

9.4 **Provider** shall notify **Humana** within twenty-four (24) hours of notice of loss of accreditation, suspension, or action taken that could result in loss of accreditation of the **Provider**, inclusive of all documentation from the accrediting body.

9.5 **Provider** shall maintain, at no expense to **Humana**, policies of comprehensive general liability, professional liability, and workers' compensation coverage, insuring **Provider** and **Provider's** employees and agents against any claim or claims for damages arising as a result of injury to property or person, including death, occasioned directly or indirectly in connection with the provision of Covered Services contemplated by this Agreement and/or the maintenance of **Provider's** facilities and equipment. **Provider** shall report **to Humana** immediately any cancellation of any required insurance coverage, licensure, or certification. Upon receipt of this report, **Humana** shall immediately notify the **Provider** that it is prohibited from performing any Covered Service unless and until **Provider** provides written documentation to **Humana** that **Provider** has reinstated all required insurance coverage, licensure, or certification.

9.6 **Provider** shall be bound by all applicable non-compliance actions imposed by Louisiana on **Provider** and shall inform **Humana** immediately upon receipt of notice by the state of Louisiana of any non-compliance. **Provider** agrees that **Humana** shall comply timely with all non-compliance actions imposed by LDH on network providers, including enrollment revocation, termination, and exclusions.

10. PROVISION OF MEDICAL SERVICES

10.1 **Provider** shall provide Members all available Covered Services within the normal scope of and in accordance with **Provider's**: (a) licenses and certifications, and (b) privileges to provide certain Covered Services based upon **Provider's** qualifications as determined by **Humana**. **Provider** agrees to comply with all requests for information related to **Provider's** qualifications in connection with **Humana's** determination whether to extend privileges to provide certain services and/or procedures to Members. **Provider** shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts related to the provision of Covered Services for which **Humana** has notified **Provider** that privileges to perform such services have not been extended.

10.2 Any services provided to Members via telemedicine must be Medically Necessary, and the procedure individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the Members needs.

10.3 **Provider**, while performing services to Members within the lawful scope of practice, shall not be prohibited or otherwise restricted from advising Members or advocating on a Member's behalf, for the following:

a. the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
b. any information the Member needs in order to decide among relevant treatment options;
c. the risks, benefits and consequences of treatment or non-treatment; and
d. the Member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.

10.4 **Provider** shall comply with all LDH and **Humana** continuity of care requirements for Members, including but not limited to:

a. sharing Member's health record in accordance with professional standards;
b. continuation of treatment for chronic and acute medical conditions or behavioral health conditions for up to ninety (90) Calendar Days or until the Member is reasonably transferred without interruption of care, whichever is less;
c. continuation of behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including buprenorphine/naloxone and naloxone products) prescribed to the Member in a mental health treatment facility for at least sixty (60) Calendar Days after the facility discharges the Member, unless **Humana's** psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are (i) not medically necessary or (ii) potentially harmful to the Member; and
d. support the integration of physical and behavioral health.

10.5 **Provider** shall maintain all office medical equipment including, but not limited to, imaging, diagnostic and/or therapeutic equipment (hereinafter referred to as "**Equipment**") in acceptable working order and condition and in accordance with the Equipment manufacturer's recommendations for scheduled service and maintenance. Such Equipment shall be located in **Provider's** office locations that promote patient and employee safety. **Provider** shall provide **Humana** or its agents with access to such Equipment for inspection and an opportunity to review all records reflecting Equipment maintenance and service history. Such Equipment shall only be operated by qualified technicians with appropriate training and required licenses and certifications.

10.6 Equipment owned and/or operated by **Provider** shall comply with all standards for use of such Equipment and technician qualifications established by **Humana. Provider** agrees to comply with all requests for information related to Equipment and **Provider's** and/or **Provider's** staff, qualifications for use of same. In the event: (i) **Provider's** Equipment fails to meet **Humana's** standards; or (ii) **Provider** declines to comply with **Humana's** standards for use of Equipment, **Provider** agrees that it will not use such Equipment while providing Covered Services to Members and shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts for Covered Services with respect to such Equipment.

10.7 **Humana** prohibits pass-through billing. Pass through billing occurs when the ordering physician requests and bills for a service, but the service is not performed by the ordering physician or those under their direct employ. **Provider** agrees that services related to pass-through billing will not be eligible for reimbursement from **Humana** and **Provider** shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts related to the provision of pass-through billing.

10.8 In order to ensure Members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, **Humana** will not enter into any contractual arrangement with any provider that prohibits contracting with another Managed Care Organization (MCO) or in which **Humana** represents or agrees that it will not contract with

another provider. **Humana** will not advertise or otherwise hold itself out as having an exclusive relationship with any Medicaid service provider.

10.9 If **Provider** is a primary care provider ("PCP") the following provisions shall apply:

a. **Provider** shall manage and coordinate the medical and behavioral health care needs of Members receiving services from **Provider** to ensure that all medically necessary services are made available to Members in a timely manner;
b. **Provider** shall refer Members to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;
c. **Provider** shall communicate with all other levels of medical care to coordinate and follow up the care of Members;
d. **Provider** shall provide the coordination necessary for the referral of Members to specialists;
e. **Provider** shall maintain a medical record of all services rendered by the **Provider** and a record of referral to other providers and any documentation provided by rendering provider to **Provider** for follow up and/or coordination of care;
f. **Provider** shall develop plans of care for Members to address risks and medical needs and other responsibilities as defined in this section;
g. **Provider** shall ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 C.F.R. parts 160 and 164 and all Louisiana statutes;
h. **Provider** shall provide after-hours availability to members who need medical advice. At a minimum, the **Provider** office shall have a return call system staffed and monitored in order to ensure that the Member is connected to a designated medical practitioner within thirty (30) minutes of the Member's call;
i. **Provider** shall maintain hospital admitting privileges or arrangements with a physician who has admitting privileges at a hospital that is participating in a **Humana** Medicaid plan;
j. **Provider** shall work with **Humana** case managers to develop plans of care for Members receiving case management services;
k. **Provider** shall participate in **Humana's** case management team, as applicable and medically necessary; and
l. **Provider** shall provide basic behavioral health services and conduct screens of Members for common behavioral issues, including, but not limited to, depression, anxiety, trauma/adverse childhood experiences ("ACE's"), and substance use, early detection, identification of developmental disorders/delays, social-emotional health, and Social Determinants of Health ("SDOH") to determine whether the Members need behavioral health services.

11. STANDARDS OF PRACTICE

11.1 Covered Services shall be made available to Members without differentiation or discrimination on the basis of type of program membership, source of payment, employment status, socioeconomic status, income status, sex, gender identity, sexual preference, age, race, color, creed, ethnicity, religion, national origin ancestry, marital status, health status, disability, physical, behavioral, or cognitive disability, except where medically necessary, military service, or veterans' status. **Provider** shall provide Covered Services to Members in the same manner as provided to their other patients and in accordance with prevailing practices and standards of the profession.

11.2 **Provider** shall offer the same services to Members as those offered to individuals not receiving services through the Louisiana Medicaid Program, provided they are Covered Services. **Provider** shall treat Members equally in terms of scope, quality, duration, and method of delivery of services, unless specifically limited by regulation. **Providers** are not required to accept every member requesting service.

11.3 **Provider** agrees to provide physical access, reasonable accommodations, and accessible equipment for Members with physical or behavioral health disabilities.

11.4 **Provider** shall meet LDH standards for timely access to care and services, taking into account the urgency of the need for services. Reference **Humana's** Louisiana Medicaid Provider Manual, Provider Services, Access to Care for access standards.

11.5 **Provider** shall offer hours of operation to Members that are no less than the hours of operation offered to persons with commercial health insurance or comparable to Medicaid FFS, if **Provider** serves only Medicaid enrollees. The appointment accessibility standards established by LDH are hereby incorporated into this Attachment and shall be met by **Provider**.

11.6 **Provider** shall comply with the Americans with Disabilities Act ("ADA") requirements and provide physical access for Members with disabilities.

11.7 **Provider** shall accept Members for treatment and shall not intentionally segregate Members in any way from other persons receiving services.

11.8 **Provider** shall not exclude treatment or placement of Members for authorized behavioral health services solely on the basis of Louisiana state agency (DCFS or OJJ, etc.) involvement or referral.

11.9 **Provider** shall offer the same services to Members as those offered to individuals not receiving Medicaid, provided that they are covered services under the Member's **Humana** Medicaid health benefit plan. **Provider** shall also treat Members equally in terms of scope, quality, duration, and method of delivery of services, unless specifically limited by applicable Louisiana regulation.

11.10 Any **Provider** who performs personal care services (PCS) and home health care services must use the state-contracted electronic visit verification (EVV) system as directed by LDH.

11.11 Behavioral health providers must screen for basic medical issues.

11.12 **Provider** agrees to report any incidents (including suspected abuse, neglect or exploitation) to Adult Protective Services or Child Protective Services, or **Humana** within the timeframes defined in the Manual.

12. MEDICAL RECORDS

12.1 **Provider** shall prepare, maintain and retain as confidential the medical records of all Members receiving Covered Services, and Members' other personally identifiable health information received from **Humana**, in a form and for time periods required by LDH, applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which **Provider** is subject, and in accordance with accepted medical practice.

12.2 **Provider** shall maintain an individual medical record for each Member receiving services as outlined within Manual. **Provider** shall retain all documentation and/or medical records for at least ten (10) years after the last service has been provided to a Member.

12.3 **Provider** must provide any information related to the performance of contract responsibilities as requested by LDH. **Humana** will forward such information to LDH.

12.4 If applicable, **Provider** must comply with the data submission requirements of La. R.S. 40:1173.1 through 1173.6., including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:II.105). **Humana** encourages the use of Health Information Exchanges where direct connections to public health reporting information systems are not feasible or are cost prohibitive.

12.5 **Provider** shall obtain authorization of Members permitting **Humana** or its designee, and/or any state or federal agency as permitted by law, to obtain a copy and have access, upon reasonable request, to any medical record of Member related to Covered Services provided by **Provider** pursuant to applicable state and federal laws. Medical records shall be provided by **Provider** to **Humana** at no cost to **Humana** or the Member. **Provider** will use best efforts to provide medical records electronically. If **Provider** utilizes a vendor to provide medical records to **Humana**, **Provider** agrees **Humana** is only obligated to pay the vendor the amount specified for medical records in this Agreement and further agrees to require its vendor to accept that amount as payment in full. Any expense for Medical Records in excess of the fees outlined in this Agreement shall be the responsibility of the **Provider**. Upon the written request of **Humana** and unless applicable law requires otherwise, **Provider** shall provide an agreed upon, electronic, automated

means, at no cost, for **Humana** or its designee to access Member clinical information including, but not limited to, medical records for all **Humana** health plan functions including but not limited to case management, utilization management, claims review and audit, and claims adjudication.

12.6 **Provider** and **Humana** agree, and **Humana** will require its designee to agree, to maintain the confidentiality of information maintained in the medical records of Members, and information obtained from **Humana** through the verification of Member eligibility, as required by law. This Section 12 shall survive expiration or termination of this Agreement, regardless of the cause.

13. CLAIMS RECONSIDERATIONS AND DISPUTES

All claims disputes procedures are subject to approval of LDH and details regarding the procedures will be published in LDH Informational Bulletin 19-3.

13.1 **RECONSIDERATION REQUESTS** **Provider** may contest the amount of the payment, denial or nonpayment of a claim only within a period of one hundred eighty (180) days following the date such claim was paid, denied or not paid by the required date by **Humana**. In order to contest such payments, **Provider** shall provide to **Humana**, at a minimum, in a clear and acceptable written format, the following information: 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, difference between the amount paid and the allegedly correct payment amount, and a brief explanation of the basis for the contestation. **Humana** will make a determination within thirty (30) calendar days or any successor date which may be required.

13.2 **CLAIMS APPEALS** **Provider** may submit a written appeal for a claim dispute/reconsideration within the timeframe specified within the Manual from the date on the determination letter from the original request for claim reconsideration. **Humana** will make a determination within thirty (30) calendar days or any successor date which may be required.

13.3 **INDEPENDENT REVIEW** In the event **Provider** has completed **Humana's** appeals process and **Provider** remains dissatisfied with **Humana's** determination, **Provider** may either submit a written request for arbitration per 13.4, below, or may initiate the independent review process as established by La. R.S. 46:460.81, et. seq. and further described in the Manual. **Provider** shall follow the process within the Manual when initiating the independent review process. The parties agree that an adverse determination may be pursued through either the Independent Review process or arbitration, but not both, in accordance with state laws, rules and regulation.

13.4 **ARBITRATION REGARDING CLAIMS DISPUTES** In the event **Provider** has completed **Humana's** dispute process and **Provider** remains dissatisfied with **Humana's** determination, **Provider** may submit a written request for arbitration within the timeframe specified in the Manual. The request should include decisions from all claim reconsideration requests and claim appeals. Any such arbitration shall be subject to Section 14, below. Notwithstanding anything to the contrary in Section 14 below, for arbitration regarding claims disputes, the arbitrator shall conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless the parties mutually agree to extend this deadline.

13.5. **ESCALATIONS** **Humana** and **Provider** agree to comply with the escalation processes per the LDH Informational Bulletin 19-3.

14. ARBITRATION

14.1 **INTERNAL ADMINISTRATIVE REVIEW** **Provider** and **Humana** agree that in the event they are unable to resolve disputes that may arise with respect to this Agreement, **Provider** will first exhaust any internal **Humana** administrative review or appeal procedures prior to submitting any matters to binding arbitration.

14.2 **AGREEMENT TO ARBITRATE** The parties agree that any dispute arising out of their business relationship which cannot be settled by mutual agreement may be submitted to final and binding arbitration under the Healthcare Payor Provider Arbitration Rules of the American Arbitration

Association ("AAA"), including disputes concerning the scope, validity or applicability of this agreement to arbitrate ("Arbitration Agreement"). The parties agree that this Arbitration Agreement is subject to, and shall be interpreted in accordance with, the Federal Arbitration Act, 9 U.S.C. §§ 1-16. No claim or allegation shall be excepted from this Arbitration Agreement, including alleged breaches of the Agreement, alleged violations of state or federal statutes or regulations, tort, or other common law claims, and claims of any kind that a party to the Agreement has conspired or coordinated with, or aided and abetted, one or more third parties in violation of law. Without limiting the foregoing, this Arbitration Agreement requires arbitration of disputes involving antitrust, racketeering and similar claims. This Arbitration Agreement supersedes any prior arbitration agreement between the parties. The parties agree to arbitrate disputes arising from the parties' business relationship prior to the effective date of the Agreement under the terms of this arbitration provision. This Arbitration Agreement, however, does not revive any claims that were barred by the terms of prior contracts, by applicable statutes of limitations or otherwise.

14.2 **ARBITRATION PROCESS** The arbitration shall be conducted by one neutral arbitrator selected by the parties from the AAA National Healthcare Panel of arbitrators. The arbitrator shall have prior professional, business or academic experience in health care, managed care or health insurance matters. In the event of an arbitration of antitrust claims, the arbitrator shall have prior professional, business or academic experience in antitrust matters. The arbitration shall be conducted in a location selected by mutual agreement or, failing agreement, at a location selected by the AAA that is no more than fifty (50) miles from **Provider's** place of business. The cost of any arbitration proceeding(s) hereunder shall be borne equally by the parties. With respect to any arbitration proceeding between **Humana** and **Provider** whereby **Provider** practices individually or in a provider group of less than six (6) providers, **Humana** agrees that it shall refund any applicable filing fees or arbitrators' fees paid by such **Provider** in the event that **Provider** is the prevailing party with respect to such arbitration proceeding; provided, however, that this paragraph shall not apply with respect to any arbitration proceeding in which **Provider** purports to represent providers outside his or her provider group. Each party shall be responsible for its own attorneys' fees and such other costs and expenses incurred related to the proceedings, except to the extent the applicable substantive law specifically provides otherwise.

14.3 **JOINDER: CLASS LITIGATION** Any arbitration under this Arbitration Agreement shall be solely between **Humana** and **Provider**, shall not be joined with another lawsuit, claim, dispute or arbitration commenced by any other person, and may not be maintained on behalf of any purported class.

14.5 **EXPENSE OF COMPELLING ARBITRATION** If either party commences a judicial proceeding asserting claims subject to this Arbitration Agreement or refuses to participate in an arbitration commenced by the other party, and the other party obtains a judicial order compelling arbitration of such claims, the party that commenced the judicial proceeding or refused to participate in an arbitration in violation of this Arbitration Agreement shall pay the other party's costs incurred in obtaining an order compelling arbitration, including the other party's reasonable attorneys' fees.

14.6 **JUDGMENT ON THE DECISION AND AWARD** Judgment upon the decision and award rendered by an arbitrator under this Arbitration Agreement may be entered in any court having jurisdiction thereof.

15. MEMBER GRIEVANCES

15.1 **MEMBER RIGHTS** Information about Member's right, and the availability of assistance, to file grievances and appeals, request State Fair Hearings, and request continuation of benefits are located in the Manual.

15.2 **MEMBER GRIEVANCES AND APPEALS** **Provider** shall cooperate and participate with **Humana** in grievance and appeals procedures to resolve disputes that may arise between **Humana** and its Members including any Appeal or State Fair Hearing processes contained within the Manual.

16. USE OF PROVIDER'S NAME

16.1 **Humana** may include the following information in any and all marketing and administrative materials published or distributed in any medium: **Provider** name, telephone number, address, office hours, type of practice or specialty, hospital affiliation, Internet web-site address, and the names of Participating Providers, including providers providing care at **Provider's** office, and hospital affiliation, board certification, and other education and training history, if applicable, of Participating Providers. **Provider** will provide **Humana** with and maintain current information at all times including but not limited to electronic mail address, physical mailing addresses, all telephone and fax numbers. **Humana** will provide **Provider** with access to such information or copies of such administrative or marketing materials upon request.

17. PAYMENT

17.1 **Provider** shall accept payment from **Humana** for those Covered Services for which benefits are payable under Member's Plan in accordance with the reimbursement terms in the Payment Attachment. **Provider** shall collect directly from Member any co-payment, coinsurance, or other Member cost share amounts (hereinafter referred to as "Copayments") applicable to the Covered Services provided and shall not waive, discount or rebate any such Copayments. Payments made in accordance with the Payment Attachment less the Copayments owed by Members pursuant to their health benefits contracts shall be accepted by **Provider** as payment in full from **Humana** for all Covered Services. This provision shall not prohibit collection by **Provider** from Member for any Covered Services not covered under the terms of the applicable Member health benefits contract.

17.2 **Provider** agrees, as a condition of receiving payments from **Humana** hereunder, in acknowledgement that those funds are derived from the Medicaid Program, to comply with all Federal and State laws, rules, regulations and Manual for fraud, waste and abuse prevention. **Provider** agrees to cooperate, assist and shall give the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided to the State and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste, or Abuse, at the providers office, during business hours except under special circumstances determined by the MFCU when after-hours admissions shall be allowed by Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG), the United States Department of Health and Human Services (HHS), LLA, the Office of Attorney General, the Government Accountability Office (GAO), LDH, and/or any of the designees of the above, as often as they may deem necessary.

17.3 **Provider** agrees that payment will be made in accordance with the terms and conditions within Manual and may not be made by **Humana** for Covered Services rendered to Members which are determined by **Humana** not to be Medically Necessary. Medically Necessary Services (or "Medical Necessity") Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Member. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Member requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA)approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary. **Provider** agrees that in the event of a denial of payment for Covered Services rendered to Members determined not to be Medically Necessary by **Humana**, that **Provider** shall not bill, charge, seek payment or have any recourse against Member for such services

17.4 **Humana** and **Provider** will abide by the recoupment process within Manual.

17.5 **Provider** agrees that **Humana** may recover overpayments made to **Provider** by **Humana** by offsetting such amounts from later payments to **Provider**, including, without limitation, making retroactive adjustments to payments to **Provider** for errors and omissions relating to data entry errors and incorrectly submitted claims or incorrectly applied discounts. **Humana** may make retroactive adjustments to payments for a period not to exceed twelve (12) months from receipt date of a clean claim.

17.6 Nothing contained in this Agreement is intended by **Humana** to be a financial incentive or payment that directly or indirectly acts as an inducement for **Provider** to limit Medically Necessary services.

17.7 If applicable, **Humana** shall have no responsibility for the payment of graduate medical education ("GME) payments or disproportionate share hospital ("DSH") payments to **Provider**.

18. SUBMISSION OF CLAIMS

18.1 **Provider** shall submit all claims and encounters to **Humana** or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") compliant 837 electronic format, or a UB-04 and/or a CMS 1500 paper format (in accordance with industry standard), or their successors. Claims and encounters will utilize HIPAA compliant Code Sets for all coded values. Claims shall include the **Provider's** NPI and the valid taxonomy code that most accurately describes the Covered Services reported on the claim. Claims shall be submitted within three hundred sixty-five (365) days from the date of service, including claims involving third party liability (excluding Medicare). When Medicare is primary payor, **Provider** will submit claim within one-hundred eighty (180) calendar days from Medicare's EOB of payment or denial. **Humana** may, in its sole discretion, deny payment for any claim(s) received by **Humana** after the later of the dates specified above. **Provider** acknowledges and agrees that Members shall not be responsible for any payments to **Provider** except for applicable Copayments and non-covered services provided to such Members.

18.2 Notwithstanding any other terms specified in this Agreement, **Humana** and **Provider** will abide by the claims submission process within the Manual.

18.3 **Humana** will process provider claims which are accurate and complete in accordance with LDH requirements or if processing not described by LDH, within **Humana's** normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing.

18.4 Unless applicable law mandates submission may be in paper format, **Provider** shall use best efforts to submit all claims, encounters, and clinical data to **Humana** by electronic means available and accepted as industry standard, which may include claims clearinghouses or electronic data interface companies used by **Humana**. **Provider** acknowledges that **Humana** may market certain products that will require electronic submission of claims and clinical data in order for **Provider** to participate. **Provider** shall notify **Humana** when they have completed their transition to Electronic Medical Records and agrees to provide information on the status to **Humana** upon request. Unless applicable law mandates submission may be in paper format, **Provider** shall submit to **Humana** all **Humana** required clinical data (including, but not limited to, laboratory data) by available electronic means within thirty (30) days of the date of service or within the time specified by applicable law.

18.5 Notwithstanding anything to the contrary herein, **Provider** is encouraged, as an alternative to the filing of paper-based claims, to submit and receive claims information through electronic data interchange (EDI).

19. COORDINATION OF BENEFITS

19.1 When a Member has coverage, other than with **Humana**, which requires or permits coordination of benefits from a third-party payor in addition to **Humana**, **Humana** will coordinate its benefits with such other payor(s). In all cases, **Humana** will coordinate benefits payments in accordance with

applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, **Humana** will pay the lesser of: (i) the amount due under this Agreement; (ii) the amount due under this Agreement less the amount payable or to be paid by the other payor(s); or (iii) the difference between the primary Payor's allowed amount and the amount paid by the other payor(s). In no event, however, will **Humana**, when its plan is a secondary payor, pay an amount, which, when combined with payments from the other payor(s), exceeds the rates set out in this Agreement; provided, however, if Medicare is the primary payer, **Humana** will, to the extent required by applicable law, regulation or Centers for Medicare and Medicaid Services ("**CMS**") Office of Inspector General ("**OIG**") guidance, pay **Provider** an amount up to the amount **Humana** would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

20. NO LIABILITY TO MEMBER FOR PAYMENT

20.1 **Provider** agrees that in no event, including, but not limited to, nonpayment by **Humana**, **Humana's** insolvency or breach of this Agreement, shall **Provider** or any Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than **Humana** (or the payor issuing the health benefits contract administered by **Humana**) for Covered Services provided by **Provider**. This provision shall not prohibit collection by **Provider** from Member for any non-covered service and/or Copayments in accordance with the terms of the applicable Member Plan.

20.2 **Provider** further agrees that: (i) this provision shall survive the expiration or termination of this Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between **Provider** and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of **Provider**, and **Provider** shall obtain from such persons specific agreement to this provision.

21. ACCESS TO INFORMATION

21.1 **Provider** agrees that **Humana** or its designee, or any state or federal regulatory agency as required by law, shall have reasonable access and an opportunity to examine **Provider's** financial and administrative records as they relate to Covered Services provided to Members during normal business hours, on at least seventy-two (72) hours advance notice, or such shorter notice as may be imposed on **Humana** by a federal or state regulatory agency or accreditation organization.

22. ASSIGNMENT

22.1 The assignment by **Provider** of this Agreement or any interest hereunder shall require the prior written consent of **Humana**, which may be granted or withheld in **Humana's** sole discretion. Any attempt by **Provider** to assign this Agreement or any interest hereunder without complying with the terms of this section shall be void and of no effect, and **Humana**, at its option, may elect to terminate this Agreement upon thirty (30) days' written notice to **Provider**, without any further liability or obligation to **Provider**. Such right of termination shall be in addition to and not a limitation of any and all other remedies that may be available to **Humana** at law or in equity in connection with such impermissible assignment. **Humana** may assign this Agreement in whole or in part to any purchaser of or successor to the assets or operations of **Humana**, or any affiliate of **Humana**, provided that the assignee agrees to assume **Humana's** obligations under this Agreement. For purposes of this Agreement, the term "assignment" shall include a change of control of **Provider** by (i) consolidation or merger with or into any entity that, giving effect to any such transaction, results in the beneficial owners of the outstanding voting securities or other ownership interests of **Provider** immediately prior to such transaction owning less than thirty-three percent (33%) of such securities or interests after such transaction; (ii) sale, transfer or other disposition of all or substantially all of the assets of **Provider**; or (iii) acquisition by any entity, or group of entities acting in concert, of beneficial ownership of thirty-three percent (33%) or more of the outstanding voting securities or other ownership interests of **Provider**.

22.2 **Provider** agrees to comply with 42 CFR, part 455, subpart B pertaining to the disclosure of information concerning the ownership and control of **Provider**. **Provider** agrees to provide to **Humana** at least sixty (60) days notice before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location, "pay to", "mail to", email or home office, federal tax identification number(s), or change in the provider's direct or indirect ownership interest or controlling interest. Failure to provide this information may result in **Provider** termination

23. COMPLIANCE WITH REGULATORY REQUIREMENTS

23.1 **Provider** acknowledges, understands and agrees that this Agreement may be subject to the review and approval of LDH.

23.2 **Provider** and **Humana** agree to be bound by and comply with the provisions of all applicable LDH, state and/or federal laws, rules and regulations. The alleged failure by either party to comply with applicable LDH, state and/or federal laws, rules or regulations shall not be construed as allowing either party a private right of action against the other in any court, administrative or arbitration proceeding in matters in which such right is not recognized or authorized by such law or regulation. **Provider** and Participating Providers agree to procure and maintain for the term of this Agreement all license(s) and/or certification(s) as is required by applicable law and **Humana's** policies and procedures. **Provider** shall notify **Humana** immediately of any changes in licensure or certification status of **Provider** or Participating Providers. If **Provider** or any individual Participating Provider violates any of the provisions of applicable LDH, state and/or federal laws, rules and regulations, or commits any act or engages in conduct for which **Provider's** or Participating Providers' professional licenses are revoked or suspended, debarred or precluded or otherwise is restricted by or ineligible from participation any state licensing or certification agency by which **Provider** or Participating Providers are licensed or certified, **Humana** may immediately terminate this Agreement or any individual Participating Provider.

23.3 **Provider** shall procure and maintain for the term of this Agreement such enrollment, accreditation, certification, licensure and/or registration as is required by LDH and any applicable state and federal laws and regulations, and further shall ensure appropriate accreditation, certification, licensure and/or registration of all of its Participating Providers required to be so accredited, certified, licensed and/or registered, in accordance LDH and any applicable state and federal laws, rules and regulations. **Provider** shall notify **Humana** immediately of any suspensions, revocations, restrictions, terminations or any other changes in its or its Participating Providers' enrollment, accreditation, certification, licensure or registration status.

24. MISCELLANEOUS PROVISIONS

24.1 **SEVERABILITY.** If any part of this Agreement should be determined to be invalid, unenforceable, or contrary to law, that part shall be reformed, if possible, to conform to law, and if reformation is not possible, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

24.2 **GOVERNING LAW.** This Agreement shall be governed by and construed in accordance with the applicable laws of the state in which Covered Services are provided. The parties agree that applicable LDH requirements, state and/or federal laws and/or regulations may make it necessary to include in this Agreement specific provisions relevant to the subject matter contained herein.

24.3 **WAIVER.** The waiver, whether express or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent or continuing breach of the same provision. In addition, the waiver of one of the remedies available to either party in the event of a default or breach of this Agreement by the other party shall not at any time be deemed a waiver of a party's right to elect such remedy at any subsequent time if a condition of default continues or recurs.

24.4 **NOTICES.** Any notices, requests, demands or other communications, except notices of changes in policies and procedures pursuant to **Section 8**, required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been given: (i) on the date of personal delivery; or (ii) provided such notice, request, demand or other communication is received by the

party to which it is addressed in the ordinary course of delivery: (a) on the third day following deposit in the United States mail, postage prepaid or by certified mail, return receipt requested; (b) on the date of transmission by facsimile transmission; or (c) on the date following delivery to a nationally recognized overnight courier service, each addressed to the other party at the address set forth below their respective signatures to this Agreement, or to such other person or entity as either party shall designate by written notice to the other in accordance herewith. **Humana** may also provide such notices to **Provider** by electronic means to the e-mail address of **Provider** set forth on the Cover Sheet to this Agreement or to other e-mail addresses **Provider** provides to **Humana** by notice as set forth herein. Unless a notice specifically limits its scope, notice to any one party included in the term "**Provider**" or "**Humana**" shall constitute notice to all parties included in the respective terms.

24.5 **CONFIDENTIALITY.** **Provider** agrees that the terms of this Agreement and information regarding any dispute arising out of this Agreement are confidential and agrees not to disclose the terms of this Agreement nor information regarding any dispute arising out of this Agreement to any third party without the express written consent of **Humana**, except pursuant to a valid court order, or when disclosure is required by a governmental agency. Notwithstanding anything to the contrary herein, the parties acknowledge and agree that **Provider** may discuss the payment methodology included herein with Members requesting such information.

24.6 **COUNTERPARTS, HEADINGS AND CONSTRUCTION.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, and all of which together constitute one and the same instrument. The headings in this Agreement are for reference purposes only and shall not be considered a part of this Agreement in construing or interpreting any of its provisions. Unless the context otherwise requires, when used in this Agreement, the singular shall include the plural, the plural shall include the singular, and all nouns, pronouns and any variations thereof shall be deemed to refer to the masculine, feminine or neuter, as the identity of the person or persons may require. It is the parties' desire that if any provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is to be construed against its drafter shall not apply to the interpretation of the provision.

24.7 **INCORPORATION OF ATTACHMENTS.** All attachments attached hereto are incorporated herein by reference.

24.8 **FORCE MAJEURE.** Neither party to this Agreement shall be deemed to breach its obligations under this Agreement if that party's failure to perform under the terms of this Agreement is due to an act of God, riot, war or natural disaster.

24.9 **ENTIRE AGREEMENT.** This Agreement, including the attachments, addenda and amendments hereto and the documents incorporated herein, constitutes the entire agreement between **Humana** and **Provider** with respect to the subject matter hereof, and it supersedes any prior or contemporaneous agreements, oral or written, between **Humana** and **Provider**.

24.10 **MODIFICATION OF AGREEMENT.** This Agreement may be amended in writing as mutually agreed upon by **Provider** and **Humana**. In addition, **Humana** may amend this Agreement as needed to comply with federal or state laws, rules or regulation, or LDH requirements, by providing ninety (90) days' written notice or such other time for notice that may be required by law, rule, regulation, or LDH.

24.11 **TERMS AND DEFINITIONS**. The following terms in the Agreement or the Manual shall be defined as below with regard to services provided to Louisiana Medicaid Plan Members:

a. Appeal shall mean a request for a review of an adverse benefit determination.
b. Clean Claim shall mean a claim that can be processed without obtaining additional information from **Provider** or a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from **Provider** in the event provider is under investigation for fraud or abuse, or a claim under review for medical necessity.
c. Co-payment shall mean a fixed amount per medical service for which the Member is responsible. This is a type of cost sharing arrangement and must be in accordance with 42 CFR

§438.108 and Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) for Native American Enrollees.

d. Denied Claim shall mean a claim for which no payment is made to **Provider** for any of several reasons, including but not limited to, the claim is not for Covered Services**, Provider** is ineligible for participation in Louisiana Medicaid Programs, patient receiving the services provided is not a Member, claim is a duplicate of another transaction, or has failed to pass a significant requirement in **Humana** claims processing system.

e. Durable Medical Equipment, Prosthetics, Orthotic and Certain Supplies ("**DMEPOS**") shall mean and be inclusive of equipment which 1) can withstand repeated use, 2) is primarily customarily used to serve a medical purpose, 3) generally is not useful to a person in the absence of illness or injury, and 4) is appropriate for use in the home. POS is inclusive of prosthetics, orthotics and certain supplies. Certain supplies are those medical supplies that are of an expendable nature, such as catheters and diapers.

f. Emergency Medical Condition shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

g. Emergency Medical Transportation shall mean transportation provided for an Emergency Medical Condition.

h. Emergency Room Care shall mean emergency services provided in an emergency department.

i. Emergency Services Covered inpatient and outpatient services that are as follows: (a) furnished by a provider that is qualified to furnish these services under Title 42 of the Code of Federal Regulations and Title XIX of the Social Security Act; and (b) needed to evaluate or stabilize an Emergency Medical Condition.

j. Excluded Services shall mean those services that Members may obtain under the State Plan or applicable Waivers and for which **Humana** is not financially responsible.

k. Grievance shall mean an expression of Member dissatisfaction about any matter other than an Adverse Benefit Determination as defined in this Agreement. Examples of grievances include, but are not limited to, dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

l. Habilitation Services and Devices shall mean health care services that help Members keep, learn, or improve skills and functioning for daily living.

m. Health Insurance shall mean a type of insurance coverage that pays for medical and surgical expenses incurred by the insured. Health insurance can reimburse the insured for expenses incurred from illness or injury or pay the care provider directly.

n. Home Health Care or Services shall mean patient care services provided in the patient's residential setting or any setting in which normal life activities take place under the order of a physician that are necessary for the diagnosis and treatment of the patient's illness or injury, including one or more of the following services:(1) skilled nursing; (2) physical therapy; (3) speech-language therapy; (4) occupational therapy; (5) home health aide services; or (6) medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place.

o. Hospice Care or Services shall mean an alternative treatment approach that is based on a recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and supporting family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

p. Hospital Outpatient Care shall mean care in a hospital that usually doesn't require an overnight stay.

q. Hospitalization shall mean admission to a hospital for treatment.

r. Medicaid Provider shall mean any service provider contracted with **Humana** and/or enrolled in the Louisiana Medicaid Program.

s. Medically Necessary Services shall mean those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective

professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Member. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Member requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary.

t. Network shall mean the collective group of providers who have entered into **Provider** Agreements with **Humana** for the delivery of **Humana** Covered Services. This includes, but is not limited to physical, behavioral, pharmacy, and Ancillary Service providers. Also referred to as Provider Network.

u. Network Provider or Provider shall mean an appropriately credentialed and licensed individual, facility, agency institution, organization or other entity, and its employees and subcontractors that has a signed Network Provider Agreement with **Humana** for the delivery of **Humana** Covered Services to the **Humana's** Members.

v. Physician Services shall mean the services provided by an individual licensed under State law to practice medicine or osteopathy. It does not include services that are offered by physicians while admitted in the hospital, and charges that are included in the hospital Claim.

w. Plan shall mean an individual or group that provides, or pays the cost of, medical care.

x. Premium shall mean an amount to be paid for an insurance policy.

y. Prescription Drug shall mean a drug that can be obtained only by means of a prescription from a qualified provider.

z. Prescription Drug Coverage shall mean health insurance or plan that helps Members pay for prescription drugs and medications.

aa. Primary Care Provider (PCP) shall mean an individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of a Member's health care. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.

bb. Rehabilitation Services and Devices shall mean services ordered by the Member's PCP to help the Member recover from an illness or injury. These services are provided by nurses and physical, occupational, and speech therapists.

cc. Skilled Nursing Care shall mean a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

dd. Specialist shall mean a physician who is not a PCP. May be used interchangeably with subspecialist.

ee. Urgent Care shall mean medical care provided for a condition that without Timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily functions, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent care requires Timely face-to face medical attention within twenty-four (24) hours of Member notification of the existence of an urgent condition.

Each party to this Agreement represents that it has full power and authority to enter into this Agreement and the person signing below on behalf of either party represents that they have been duly authorized to enter into this Agreement on behalf of the party they represent. This Agreement is effective as of the Effective Date of

PROVIDER **AUTHORIZED SIGNATORY**	**HUMANA**
Legal Entity:	Signature:
Provider :	Printed Name:
Signature:	Title:
Printed Name:	Date:
Title:	
Date: Ex[illegible]e1	
Tax ID:	

Address For Notice:

Provider:	**Humana:**

Provider :	**Copy to**:
	Humana Inc
	Attn: Law Department
	P.O. Box 1438
	Louisville, Kentucky 40201-1438

PRODUCT PARTICIPATION LIST

ATTACHMENT

Provider agrees to participate in the health benefits plan(s) selected below, that are offered or administered by **Humana**.

Health Benefits Plan	
Louisiana Medicaid Plans	X

PROVIDER INFORMATION

ATTACHMENT

(To be provided by **Provider** prior to execution of this Agreement.)

Legal Name	Facility Type	DBA	Tax ID	Physical Address	City	State	Zip code

PAYMENT ATTACHMENT – LOUISIANA MEDICAID

Provider agrees to bill and accept as payment in full from **Humana** _____(XX%) of Medicaid Allowable, or **Provider's** billed charges, whichever is less, less any applicable Copayment due from Member, for Covered Services rendered to **Humana's** Louisiana Medicaid Members. **Provider** acknowledges and agrees that a Copayment may not be required from Members.