Provider Orientation and Training

Information for Medicaid Healthcare Providers and Administrators 2023

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

Humana
Healthy Horizons®
in Louisiana

78003LA0922 LAHKMA4EN

Training topics

Topic	General guidance	Page
Humana's Louisiana Medicaid Plan	• Overview of program purpose, eligibility, components and goals	5
Base covered services and value-added benefits	• Covered medical and behavioral health services • Value-added benefits • Pharmacy benefits	7
Contracting and credentialing	• Contracting process • Credentialing • Contracting and credentialing status updates	15
Clinical	• Utilization management • Referrals • Prior authorizations • Inpatient utilization management • Drug utilization review • Pharmacy – Drug prior authorization and notification • Prescriber quick reference guide • Access-to-care requirements • Continuity of care • Transitioning during pregnancy • Care coordination support • Member screening – behavioral health problems and disorders	22

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.)

Topic	General guidance	Page
Care management programs	• Care management initial process and ongoing • Chronic condition management • Members with Special Health Care Needs • Maternal health and transition programs • Population health and incentive programs • Member referral to care management programs	39
Claims submission and processing	• Electronic and paper claim submissions • Encounter submissions • Avoiding submission errors • Timely filing • Coordination of benefits – crossover claims • Claim disputes • Electronic claims payment option • Balance billing	50
Value-based payment	• Value-based payment program overview • Primary Care Provider Quality Recognition Programs	64
Medicaid risk adjustment	• Reimbursement calculation method and example • Documentation guidelines	67

Training topics (con’t.)

Topic	General guidance	Page
Louisiana Department of Health (LDH) provider-based marketing guidelines	• Provider marketing do’s and don’ts	75
Additional training requirements	• Training location list and how to ensure documented completion	78
Fraud, waste and abuse	• Reporting requirements, options and protections related to suspected false claims	80
Adverse incident reporting	• Reporting requirement, examples and methods	84
Humana online resources and phone numbers	• Provider public website and multi-payer provider portal • Toll-free; hours listed for non-24/7 phone numbers	86

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 Louisiana Department of Health’s (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

Base covered medical services

Base medical services include:

Allergy testing and allergen immunotherapy	Emergency services
Ambulatory surgical services	End-stage renal disease services
Anesthesia	Eye care and vision services
Applied behavioral analysis therapy (age 0-20)	Family planning services
Audiology services	Federally qualified health center (FQHC)/rural health clinic (RHC) services
Bariatric surgery	Genetic testing
Breast surgery	Glasses, contacts and Eye-Wear eyewear
Chiropractic services (age 0-20)	Gynecology
Cochlear implant (age 0-20)	Home health-extended services (age 0-20)
Diabetes self-management training	Home health services
Doula services	Hospice services
Durable medical equipment, prosthetics, orthotics and certain supplies	Hospital Services Hospital services—inpatient Inpatient Hospital Services Outpatient Hospital Services
Early periodic screening, diagnostic and treatment (EPSDT) services (age 0-20)	Hospital services—outpatient

Base covered medical services

Base medical services include:

Hyperbaric oxygen therapy	Pharmacy services
Immunizations	Physician administered medication
Inpatient Hospital Services	Physician/professional services
Intrathecal baclofen therapy	Podiatry services
Laboratory and radiology services	Pregnancy-Related Services
Limited abortion services	Preventive services for adults
Medical transportation services	Routine care provided to members participating in clinical trials
Newborn care and discharge	Sterilization
Obstetrics	Telemedicine/telehealth
Outpatient Hospital Services	Therapy services
Pediatric day healthcare services (age 0-20)	Tobacco-cessation services
Personal care services (age 0-20)	Vagus nerve stimulators

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)
      - Multi-systemic 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 (age 0-20)
  - Therapeutic group homes (TGH) (age 21 and younger)
  - Psychiatric residential treatment facilities (PRTF) (age 0-20)
  - Inpatient hospitalization (age 0-20; 65 and older)
  - Outpatient and residential substance use disorder services
  - Medication-assisted treatment

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:

- Cell phone services (all ages)
- Dental services (age 21 and older)
- Drowning prevention classes (age 21 and younger)
- GED test preparation assistance (age 16 and older)
- Home-based interventions for asthma (all ages)
- Housing assistance (age 21 and older)
- Meals – disaster preparedness/relief (all ages)

Value-added benefits (con’t.)

Humana Healthy Horizons in Louisiana offers the following value-added benefits:

- Meals – post discharge (all ages)
- Newborn circumcisions (age 0-12 months)
- Over-the-counter (OTC) allowance (all ages)
- Chronic pain management (age 21 and older)
  - Acupuncture
  - Massage therapy
- Respite Care for Homeless Program (males ages 18 and older)
- Portable cribs (all ages)
- Sports physicals (age 6-18)
- Vision services (age 21 and older)
- YMCA gym membership (all ages)

Humana Healthy Horizons in Louisiana pharmacy benefit summary

Copayments

The following co-pays 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

******During the COVID-19 public health emergency, members will not pay a co-pay for covered drugs******

Over-the-counter (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 PDL.pdf (la.gov)

Medication Therapy Management (MTM)

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

Pharmacy Lock-in Program

- 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 identified to be enrolled in the lock-in program receive written notification from Humana Healthy Horizons in Louisiana, along with the designated lock-in pharmacy's information.

- Members who meet the program criteria will be locked in to one pharmacy.

Contracting and credentialing

Contracting process

- Providers interested in contracting with Humana Healthy Horizons in Louisiana should send an email to:
  - Medical providers – lamsproviderintake@humana.com
  - Behavioral health providers – LABHMedicaid@humana.com
- Include the following in the email:
  - Physician, 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 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), the Centers for Medicare and Medicaid Services (CMS) while incorporating requirements defined by the Louisiana Department of Health (LDH) and the Office of Behavioral Health (OBH) to create a custom credentialing program focused on creating a positive provider experience.

In accordance with La. 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 three years. Some circumstance 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 is incomplete, in accordance with La. 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 at Humana.com/HealthyLA.

Initial Credentialing
- Occurs prior to providers being made available to members.
- 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's BH Provider Manual.
- Required credentialing documents are available at Humana.com/HealthyLA.

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

Credentialing and Recredentialing

Types of Practitioners to Credential:

Physical Health Practitioners

- Medical Doctors
- Doctor of Osteopathic Medicine
- 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 Behavioral Health Practitioners

Psychiatrists:
- MD
- DO

LMHPs:
- Medical Psychologists
- Licensed Psychologists
- LCSWs
- LPCs
- LMFTs
- LACs
- BH – ARPNs
- BH – CNSs

Provisionally Licensed and Interns Rendering Behavioral Health Services

As permitted by service and provider qualifications:

- Provisionally licensed professional counselors (PLPC)
- Provisionally licensed marriage & family therapist (PLMFT)
- Psychology intern from an APA approved internship program

Unlicensed Individuals Rendering Behavioral Health Services

As permitted by service and provider qualifications:

- Certain individuals employed by an accredited BHSP that 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 BHSP that 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
- PT/OT/SLP 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 Providers (BHSP) Types

- Hospitals
- Residential
  - Therapeutic Group Home (TGH)
  - Psychiatric Residential Treatment Facility (PRTF)
  - Crisis Stabilization for Adults
- Agencies rendering EBP services
- Agencies rendering addiction services, including inpatient, residential, intensive-partial outpatient and outpatient
- Agencies rendering CSoC services
- Outpatient
  - Peer Support
  - Personal Care
  - Individual Placement & Support
  - RHCs & FQHCs rendering BH services
  - PSR
  - Crisis Intervention
  - Crisis Stabilization
  - CPST

Contracting and credentialing status updates

To check the 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)

Utilization management helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons in Louisiana members.

- Provides on-site and telephonic 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 non-participating providers:

- Emergency care
- Care at community mental health centers
- Family planning services provided at qualified family planning providers (e.g., Planned Parenthood)
- Care at federally qualified health centers (FQHCs) and rural health clinics (RHCs)

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

Non-participating providers must be LDH-enrolled as a Medicaid provider to receive payment.

Prior authorizations

- Humana Healthy Horizons in Louisiana 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 LDH coverage policies.
- Physicians or other healthcare providers should review the "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 caesarean 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 Utilization Management department online or by phone:

- Visit the provider portal at www.Availity.com
- Call 1-888-285-1113 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.com

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 utilization management (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 in Louisiana care or disease management programs
- Refers member to community resources or Humana Healthy Horizons in Louisiana social worker when social issues place member at risk for readmission

Drug utilization review

Behavioral Health

Provider communications
Prescribers are notified via letter or fax when member's utilization is:

- Antipsychotics medications with a diagnosis of dementia when no evidence of psychosis
- Utilizing single and/or multi-classes of behavioral health medications at the same time
- Utilizing one or more selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs) or subtherapeutic dosages incorrectly
- Non-adherent or close to becoming non-adherent (less than 80% adherence rate) for either antipsychotic and/or antidepressant medications

Safety edits at time of dispensing
Prior authorization is required for:

- Members 65 years or older when filling an antipsychotic medication with diagnosis of dementia
- Members younger than 17 when filling at least two antipsychotic medications

Opioid and Pain Management

Safety edits at time of dispensing
Acute pain

- Seven-day quantity limit for opioid-naïve recipients or Morphine Milligram Equivalent (MME) limit of 90 milligram per day, whichever is less*

Chronic pain

- MME limit of 90 milligram per day for all opioid prescriptions*

Prior authorization is required to exceed the established quantity limits.

*All patients with a diagnosis of cancer, in need of palliative care or with diagnosis of have terminal illness, second/third degree burns or sickle cell crisis are excluded from the opioid limits.

For more information, please visit https://ldh.la.gov/assets/opioid/OpioidFactSheet.pdf.

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 (PA), step therapy, quantity limits and medication exceptions. To view Humana's drug list, please visit Humana.com/PAL.

Prior authorizations are obtained through the University of Louisiana at Monroe (ULM) College of Pharmacy. Prior authorizations can be requested by phone, fax or mail.

- **Phone submissions:** 1-866-730-4357
- **Faxed submissions:** 1-866-797-2329 **(Do not include a cover sheet)**
- **Mail submissions:** ULM
  College of Pharmacy "Rx PA Program"
  1800 Bienville Drive
  Monroe, LA 71201-3765

Providers can find forms at www.lamedicaid.com or by calling 1-866-730-4357. Hours of operation are Monday through Friday, 8 a.m. to 6 p.m.

Access-to-care requirements

Participating PCPs and specialists are required to ensure adequate healthcare accessibility:

- 24 hours a day, seven days a week;
- may not discriminate against members;
- after-hours telephone number must be answered by a live agent;
- voicemail is 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 non-emergency care	24 hours, 7 days a week within 24 hours of request
Non-urgent sick, primary care	72 hours
Non-urgent 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
Non-urgent, routine behavioral healthcare	10 days
Urgent, non-emergency 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

Transitioning members will receive care even with non-participating 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 (con't.)

When a new/transitioning member is actively receiving medically necessary covered services from the previous MCO:

- Humana Healthy Horizons in Louisiana 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 in Louisiana 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.

Transitioning during pregnancy

First trimester: Humana Healthy Horizons in Louisiana 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 until Humana Healthy Horizons in Louisiana can safely transfer the member to a network provider without impeding service delivery.

Second and third trimesters: Humana Healthy Horizons in Louisiana covers the costs of continued access to the prenatal care provider (whether or not contracted with Humana Healthy Horizons in Louisiana) for 60 calendar days post-partum, provided the member remains covered through Humana Healthy Horizons in Louisiana, or referral to a safety net provider if the member's eligibility terminates before the end of the postpartum period.

Humana Healthy Horizons in Louisiana 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 in Louisiana 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 in Louisiana 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 efforts to understand any special needs requirements by members. 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 in Louisiana incorporates person-centered care planning, coordination and treatment into our care coordination program.

Care coordination support (con’t.)

- 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 in Louisiana case manager leads the member’s MDT and closely collaborates 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 in Louisiana’s predictive model identifies required potential risk and intervention levels to channel the member to the required level of coordination.

A comprehensive assessment is completed for each member to evaluate his or her medical, behavioral and psychosocial status to determine the plan of care.

Member screening – Behavioral health problems and disorders

PCPs are required to screen and evaluate for the detection, 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.

Care management programs

Care management programs

Clinical 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 in Louisiana manages and coordinates required ongoing or chronic condition management for members, based on acuity and member-determined outreach frequency.

- Humana identifies members through referrals from on-site/telephonic 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 identifies key members of member's interdisciplinary care team and engages the PCP.
- The care manager creates an individualized comprehensive care plan with the member and works toward identified goals.
- The care manager coordinates care to meet identified needs and works with member to set agreed-upon contact frequency and cadence.
- The individualized plan of care is available to providers by contacting Humana Healthy Horizons in Louisiana or through the provider portal.

Care management – ongoing

Humana Healthy Horizons in Louisiana 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.

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

Chronic condition management

Programs

- 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 compliance and better health outcomes

Overview

- Participation is voluntary and members may opt out at any time.
- Referral sources include claims data, on-site or telephonic nurses, post-discharge, PCPs, self-referral, internal and external programs and community partners.
- Assessment data sources include health history, cognitive/ psychological/depression screening, medication review and diet compliance.
- An interdisciplinary team approach is applied.
- The care manager creates an individualized comprehensive care plan with the member and works toward identified goals.
- The care 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. 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 (con’t.)

- Humana Healthy Horizons in Louisiana care managers encourage and assist members in receiving care from their PCPs.
- Care managers reinforce the physician’s plan of care and facilitate the utilization of services that promote wellness and prevent unnecessary hospital admissions.

Members with Special Health Care Needs (SHCN)

SHCN members are individuals of any age with a behavioral health disability, physical disability, developmental disability or other circumstances that place their health and ability to fully function in society at risk, requiring individualized care approaches. Members with SHCN include 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 six 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 department after a suicide attempt or non-fatal opioid, stimulant and sedative/hypnotic drug overdose
- Are homeless, as defined in Section 330(h)(5)(A) of the Public Health Services Act and codified by the US Department of Health and Human Services in 42 U.S.C. 254(b)

Members with Special Health Care Needs (SHCN) – cont'd

- Are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors), or who had an adverse pregnancy 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 department visits, including certain members transitioning care across acute hospital, chronic disease and rehabilitation hospital 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, but not limited to, programs through the Office of Juvenile Justice (OJJ), Department of Children & Family Services (DCFS) or Office of Public Health (OPH)

Maternal health and transition programs

HumanaBeginnings®™

- Manages prenatal and postpartum members from onset of pregnancy up to eight weeks postpartum.
- Facilitates care coordination with the Special Supplemental Nutrition Program for Women, Infants and Children (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, 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 in Louisiana 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 any of the care management and chronic condition management programs by contacting Humana Healthy Horizons in Louisiana.

- Call Member Services: 1-800-448-3810
- Send an email to LAMCDCaseManagement@humana.com

Claims submission and processing

Electronic claim submission – claims clearinghouses*

Availity Essentials	www.availity.com
Change Healthcare	www.changehealthcare.com
TriZetto	www.trizettoprovider.com
McKesson	www.mckesson.com
SSI Group	www.thessigroup.com

*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.”

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 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 that 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 that 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 (con't.)

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 that submitted patient information is accurate and correct
- Ensure that 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 EOB of payment or denial.
- Providers are required to file claims in a timely manner for encounters for all services rendered to enrollees.
- 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 in Louisiana to consider for secondary payment
- Part C Medicare plan or a commercial medical plan – submit claims to the primary carrier first and then file to Humana with the explanation of benefits 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: Contact Provider Services at 1-800-448-3810
Have claim reference number ready
or

Option 2: Submit claim reconsideration requests to the following address:

- Humana Healthy Horizons of in Louisiana
- Attn: Claim Reconsiderations and Appeal
- P.O. Box 14601
- Lexington, KY 40512-4601

or

Option 3: Submit claim reconsideration request through Provider Portal at Availity.com

Claims dispute management—appeal

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

Submit formal claim appeal to:

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

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

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

Receive HIPAA-compliant ERA transactions.

Get paid up to seven 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.

eBusiness 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 eBusiness consultant can help set up ERA and EFT quickly and accurately.

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

Balance billing

- Per Humana Healthy Horizons in Louisiana:
  Regarding services that are not medically necessary – 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 in Louisiana 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 in Louisiana 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 in Louisiana's value-based programs, including whether you qualify, and other quality programs available through Humana Healthy Horizons in Louisiana, please contact your provider relations representative or provider engagement associate.

Humana Healthy Horizons

Primary Care Provider (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 subset of measures.
- **Adult** and **pediatric** membership categories are measured separately.
- Program measures are updated annually within each category.

Requirements

- 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[1]

Program Highlights

- Practices can earn a per-member-per-month **(PMPM)** incentive per target achieved.
- 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[1]

Program Highlights

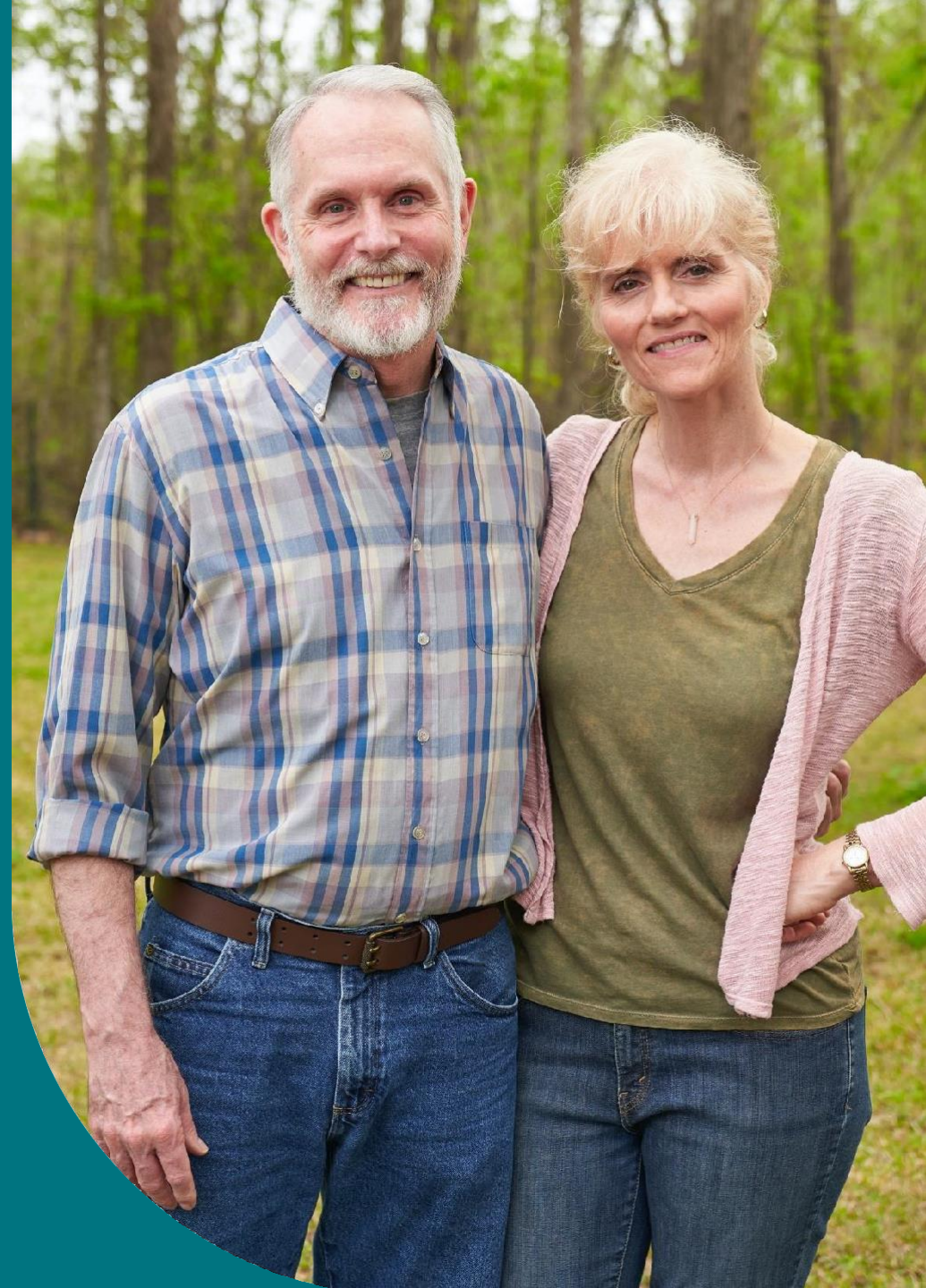
- Practices can earn a PMPM incentive per target achieved and are eligible to receive a monthly incentive payment.
- Opportunity for shared savings.
- **Adult** and **pediatric** membership categories are measured separately.
- Program measures are updated annually within each category.

Requirements

- Sign a value-based contract to participate and have a location(s) 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

[1] 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 Johns Hopkins ACG® System to develop risk adjustment scores. The relative costs were developed using Louisiana-specific historical data from Medicaid FFS claims and encounter data. LDH intends to update the managed care organization (MCO) risk scores semi-annually.

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.

Disclaimer
The information contained in this presentation and question responses are not intended to serve as official coding or legal advice. All coding decisions should be considered on a case-by-case basis and supported by medical necessity and the appropriate medical record documentation.

Johns Hopkins ACG® System

ACG is a population-based system, completely adaptable to a local context.

- Successfully tested and utilized internationally
- Cost structure
- Coding systems
- Practice behavior
- Language adaptations
- Socioeconomic data
- Living arrangements

ACG utilizes a range of diagnostic and pharmacy codes, including:

- ICPC
- ICD10
- ICD10-CM
- SNOMED CT
- NDC
- ATC
- Clinical terms

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

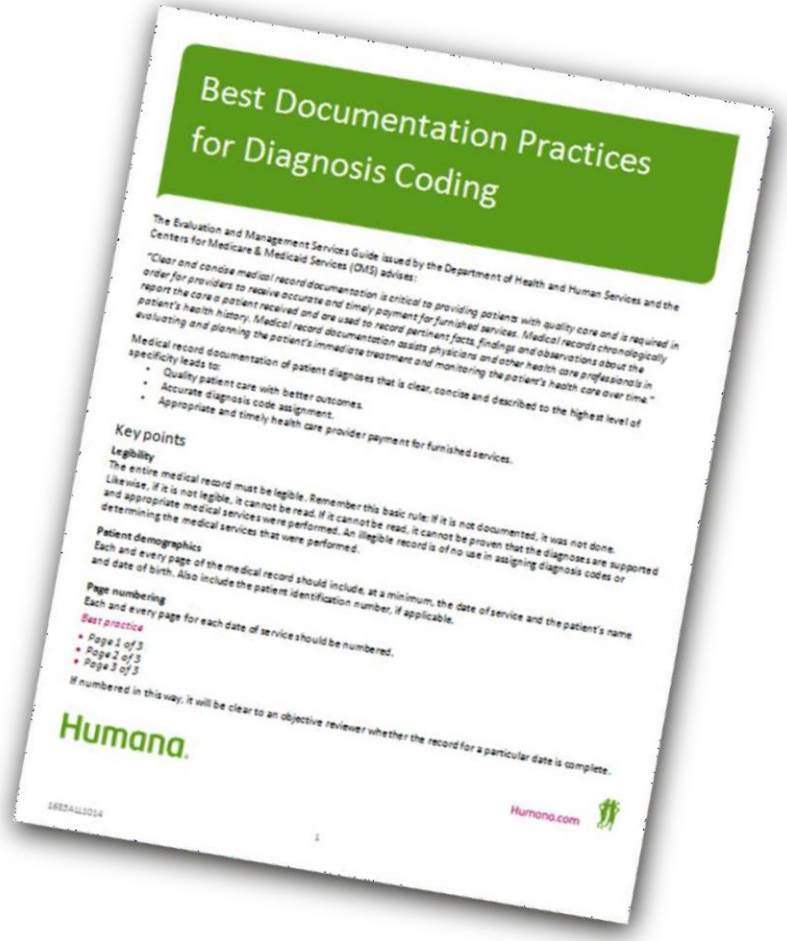
- Describes each diagnosis succinctly and to the highest level of specificity
- Limits or avoids altogether the use of abbreviations

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 (con’t.)

Assessment:

1. Diabetes mellitus, type 2, uncontrolled with hyperglycemia
2. Diabetic ulcer right ankle involving skin only
3. 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 complete blood count (CBC), comprehensive metabolic panel (CMP), thyroid-stimulating hormone (TSH), hemoglobin A1c (HbA1c), random urine albumin, urine albumin creatinine ratio.
- Diabetic teaching with nutrition consult for diabetic diet.

Example coding

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

Submitting corrected claims

To submit corrected health claims, healthcare providers can use Availity.com.

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**.
- EHRs securely **share electronic patient information** with other clinicians.
- EHRs help providers more effectively **diagnose patients, reduce medical errors and provide safer care**.

Louisiana Department of Health (LDH) provider-based marketing guidelines

LDH provider-based marketing guidelines

- No marketing materials shall be disseminated through Humana Healthy Horizons in Louisiana's 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 (con't.)

- Providers may display MCO participation stickers*, but only if stickers for all contracted MCOs are displayed.
- MCO stickers indicating the provider contract participation cannot be larger than 5 by 7 inches and 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.

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.

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.

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

These trainings are located on the following secure provider websites: Humana.com/providers and Availity.com.

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 an FWA violation must report it either to Humana or their respective organization, which must then inform Humana of the violation.

Telephone:

- Special Investigations Unit (SIU) Direct Line: 1-800-558-4444 (Monday through Friday, 8 a.m. to 4 p.m.)
- Special Investigations Unit Hotline: 1-800-614-4126 (24/7 access)
- Ethics Help Line: 1-877-5-THE-KEY (584-3539)

Email: SIUReferrals@humana.com

or ethics@humana.com

Web: www.EthicsHelpline.com

Fax: 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 (con't.)

There are several ways you can alert the Louisiana Department of Health 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: http://ldh.la.gov/index.cfm/form/22
- Recipient (member) fraud form: http://ldh.la.gov/index.cfm/form/23

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

Fax **provider** fraud complaints to 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 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 also 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; and
- Three times the amount of damages which the government sustains because of that act

A person or company who violates the False Claims Act is also 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>.
- Incident types: abuse, exploitation, neglect, death from abuse, exploitation, death
- Report to 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
  - Louisiana Department of Health Facility Complaints: https://ldh.la.gov/index.cfm/page/3768
- Humana Healthy Horizons in Louisiana 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 multi-payer provider portal

The provider portal Availity.com 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 www.Availity.com

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 transactions (EDI) with providers

Helpful numbers

- **Medicaid member/provider service:** 1-800-448-3810 (Monday through Friday, 7 a.m. to 7 p.m.)
- **Clinical Intake Team (CIT) for medical procedures:** 1-888-285-1113 (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.)
- **PA for pharmacy drugs:** 1-866-730-4357 (Monday through Friday, 8 a.m. to 6 p.m.)
- **Pharmacist prescription inquiries:** 1-800-648-0790
- **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 (con’t.)

- **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 is available to assist with:

- On-site visits
- Provider education and training
- Assistance with unresolved escalated issues
- And more!

To request a visit, send an email to: lamedicaidproviderrelations@humana.com

Humana®