Louisiana Department of Health and Hospitals
BAYOU HEALTH Informational Bulletin 12-1
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Issue:
Members Assigned to "Wrong" Health Plan or "Wrong" PCP & Health Plan's Policies and Procedures for Payment In-Network and Out-of-Network

Amerigroup

If a member contacts Member Services and requested to change their PCP, when is the change effective?

They can make the change in PCP immediately. Should a member present and you are not the PCP, but the member would like you to be, they can call the Member Services line at 800-600-4441 and change their PCP at anytime.

What is your policy during the first month of implementation in the GSA (only) in the event that someone auto-assigned to your Health Plan seek cares from their traditional PCP who is out-of-network? Will you reimburse the out-of-network provider? If so, do you require a referral in advance or notification afterward?

For the first 30 days, Amerigroup will pay in-network at their contracted rate and out of network providers at 100% Medicaid for covered services that meet medical necessity criteria for Amerigroup members. If the patient is Medicaid eligible the provider should continue the required services or treatment the patient is current receiving. Amerigroup will begin to review services for medical necessity that require pre-authorization beginning the first day of the second month of implementation in the GSA .

Are you requiring that PCPs first call your Provider Help Desk and get linked to the patient as the PCP before providing treatment?

You must ensure you are the member's assigned Primary Care Physician (PCP) prior to rendering services. If you are not the assigned PCP, the member must contact our Member Services team to request a change in his or her PCP assignment. The member may call the NCC from your office, as the change to a new PCP will take effect immediately.

Is it necessary to know a member's **Plan ID #** in order to arrange services for them?

We can access the member's information by the Plan Number or the Member's name.

Community Health Solutions (CHS)

If a member contacts Member Services and requests to change their PCP, when is the change effective?

"This change would be effective the first day of the following month if requested prior to cut-off which is generally the last Friday of the month. The change would be effective the first day of the second following month if the request is received after the last Friday of the month. Since we pay a PMPM based upon enrollment with a PCP, we can't move patients mid-month. We will provide referrals among our PCPs so that there is minimal interruption in care."

What is your policy during the first month of implementation in the GSA in the event that someone auto-assigned to your Health Plan seek cares from their traditional PCP who is out-of-network? Will you reimburse the out-of-network provider? If so, do you require a referral in advance or notification afterward?

"Out of network PCPs can continue to deliver care that was scheduled prior to implementation in the GSA for the first 30 days. We would ask that they include the referral code 2475248 in order for the claim to go through without delay."

"In an effort to ensure continuity when another PCP has been assigned to the Member that is being treated, the Provider or their staff member should contact the Member immediately and encourage them to contact CHS-LA Member Services. This will give the Member an opportunity to discuss their options so they can decide if they wish to stay with their assigned PCP and CHS-LA. "

Are you requiring that PCPs first call your Provider Help Desk and get linked to the patient as the PCP before providing treatment?

If the patient was scheduled for an appointment prior to when they became assigned to CHS-LA, the PCP can provide the treatment without calling the Provider Help Desk."

Is it necessary to know a member's Plan ID # in order to arrange services for them?

"CHS-LA will assist newly enrolled Members with arranging services whether they have a Plan ID card or not. If the Member will contact the CHS-LA Member Services line, staff will assist them in their choice of a PCP and ensure that they have the required information to schedule an appointment. If further assistance is needed, the Member will be referred internally to the RN Care Management line for assistance. "

LaCare

If a member contacts Member Services and requested to change their PCP, when is the change effective?
The change is effective immediately

What is your policy during the first month of implementation in the GSA (only) in the event that someone auto-assigned to your Health Plan seek cares from their traditional PCP who is out-of-network? Will you reimburse the out-of-network provider? If so, do you require a referral in advance or notification afterward?

LaCare will pay medically necessary OON claims without prior authorization during the 30-day transition period. Scheduled well child check-ups and sick visits are medically necessary. It doesn't matter whether or not the patients should have been auto-assigned to us; the fact is they were via the auto-assignment, so they are our Members until this error is corrected or the Member transfers to another plan.

Newly enrolled members who are receiving medically necessary covered services the day before becoming a LaCare Member, can continue to receive such medically necessary services for the first thirty (30) calendar days of enrollment, without prior authorization and without regard to whether such services are being provided by a participating or non-participating LaCare Practitioner/Provider. After thirty (30) calendar days, prior authorization requirements apply for those services identified as requiring prior authorization. LaCare will continue to provide coverage for services determined to be medically necessary for an additional sixty (60) calendar days or until the Member may be reasonably transferred without disruption, whichever is less. LaCare will not deny authorization solely on the basis that the Practitioner/Provider is not a participating LaCare Practitioner/Provider.

Are you requiring that PCPs first call your Provider Help Desk and get linked to the patient as the PCP before providing treatment?

Yes.

Is it necessary to know a member's Plan ID # in order to arrange services for them?

No. The plan ID is one of the search criteria we use to locate the member in our system. We can locate a member using a combination of any of the search criteria listed: Member Plan ID, Medicaid ID Number, DOB, SS #, First Name, Last Name and Address.

Louisiana Healthcare Connections

If a member contacts Member Services and requested to change their PCP, when is the change effective?

- **Member requested PCP change requests (with or without a previous PCP assignment) made between the 1st and the 15th of the month will take effect on the 1st of the current month or the PCP's earliest participating effective date for the month the request was made.**
- **Member requests made after the 15th of the month (with a previous PCP selected) will take effect on the 1st of the next month or the earliest effective date of the PCP's participating status for the next month.**

What is your policy during the first month of implementation in the GSA (only) in the event that someone auto-assigned to your Health Plan seek cares from their traditional PCP who is out-of-network? Will you reimburse the out-of-network provider? If so, do you require a referral in advance or notification afterward?

If the visit was scheduled prior to 2/1 we would like the PCP to contact us and we will pay at 90% of the FFS fee schedule, if three documented attempts to contract have been made or 100% if we have not completed the three documented attempts.

Are you requiring that PCPs first call your Provider Help Desk and get linked to the patient as the PCP before providing treatment?
For ease of operations we prefer prior notification, but we can, when necessary, accept notification after the fact.

Is it necessary to know a member's Plan ID # in order to arrange services for them?

No, it is not necessary. We can also validate based on the following:
Medicaid ID (that is the number we use) SS Number, Name, & DOB.
We do require 3 of the above to ensure release of information.

UnitedHealthcare Community Plan

If a member contacts Member Services and requested to change their PCP, when is the change effective?

If the member requests the change by the 25th of a month the change will take affect the first day of the month that immediately follows. If the request is received from the 26th through the end of a month the request will take affect 2 months following. For example a request received on 2/15 will take effect on 3/1. A request received on 2/28 will take effect on 4/1. If a member request the change occur immediately we will accommodate that request. If the member In the first 90 days we will not put any restrictions on PCP changes but after that we will allow one PCP change per month.

What is your policy during the first month of implementation (only) in the GSA in the event that someone auto-assigned to your Health Plan seek cares from their traditional PCP who is out-of-network? Will you reimburse the out-of-network provider? If so, do you require a referral in advance or notification afterward?

Yes during the 60 day transition period we will accept and pre-process those claims for PCPs that are not in our network but are a participating member of the state's Medicaid network.

Are you requiring that PCPs first call your Provider Help Desk and get linked to the patient as the PCP before providing treatment? I received an e-mail about long wait times and frustrated patients while the provider's office (who has contracts with all 5 Plans attempted to establish the patient as the PCP of record.

"**This is not a requirement to be done prior to the patient being seen."**

Is it necessary to know a member's Plan ID # in order to arrange services for them?

For a claim to be processed by use we have told the providers they need to provide one of these three IDs: the member UHC ID, their Medicaid ID or their SSN. We will then match the member in our system and if they do not provide the member's Medicaid ID we will pull that information from our system and add it to the claim for submission to Molina for payment. Of course all the other normal items would need to be in place, like they must be a LA Medicaid provider.