Louisiana Department of Health and Hospitals
BAYOU HEALTH Informational Bulletin 12-1
February 6, 2012; Revised March 30, 2012; Revised April 13, 2012; Revised May 25, 2012

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

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

A. 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 any time.

Q. 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?

A. 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.

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

A. 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.

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

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

Community Health Solutions (CHS)

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

A. 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 following month. If the request is received after the last Friday of the month, the change would be effective the first day of the second following month. Since we pay a PMPM based upon enrollment with a PCP, we cannot move patients mid-month. We will provide referrals among our PCPs so that there is minimal interruption in care.

Q. 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?

A. 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.

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

A. 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.

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

A. 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

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

A. The change is effective immediately

Q. 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?

A. All out-of-network (OON) providers will be treated as participating through July 31, 2012. A list of services requiring prior authorization may be found at: http://www.lacarelouisiana.com/provider/resources/priorauth/index.aspx. For services not on the prior authorization list, LaCare will pay medically necessary OON claims without prior authorization through July 31, 2012. Non-participating providers will be paid 100% of the Louisiana Medicaid Fee Schedule for medically necessary / prior authorized services during the continuity of care period ending July 31, 2012.

Beginning August 1, 2012, 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.

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

A. Yes.

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

A. 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, Social Security #, First Name, Last Name and Address.

Louisiana Healthcare Connections

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

A. Member requested PCP change request will be effective on the next calendar day following the request.

Q. 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?

A. In GSA-C, Louisiana Healthcare Connections will require a prior authorization for any covered and medically necessary services provided by a non-participating provider beginning on June 1, 2012. Non-participating providers who obtain a prior authorization will be reimbursed at 90% of the FFS fee schedule for all covered and medically necessary services provided. If a non-participating provider does not secure a prior authorization for services rendered, Louisiana Healthcare Connections will not reimburse the provider.

For purposes of this bulletin, a non-participating provider in GSA-C will include any provider who has not contracted with Louisiana Healthcare Connections and any provider with whom Louisiana Healthcare has made three documented attempts to contract with.

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

A. For ease of operations we prefer prior notification, but we can, when necessary, accept notification after the fact.

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

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

UnitedHealthcare Community Plan

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

A. If the member is within the first 90 days of their Bayou Health implementation we will not put any restrictions on PCP changes. After the first 90 days of Bayou Health Implementation we will allow one PCP change per month:

- **If member requests a PCP change by the 25th of a month, the change will take effect on the first day of the next month**

- **If member request is received after the 25th, the change will be effective 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 that the change occur immediately, we will accommodate that request.

Q. 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?

A. 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.

Q 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.

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

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

A. For a claim to be processed, we require one of these three IDs:

1. **Member UHC ID**
2. **Member LA Medicaid ID**
3. **Member SSN**

If the member's Medicaid ID is not submitted on a claim, we pull that information from our system and add it to the claim for submission to Molina for processing. (Provider of service must be a LA Medicaid provider.)