# Louisiana Department of Health
# Informational Bulletin 12-15
# Revised September 1, 2017

## Referral and Prior Authorization Policies

**Aetna**

**Quick Reference:** http://www.aetnabetterhealth.com/louisiana/assets/pdf/providers/PA-List-LA.pdf

**Applicable Definitions:**

> **Referral -** This is a form your doctor gives members so the member can get care from a specialist or health care facility. It may be written or sent by computer. This allows for effectively management of medical/behavioral services in order to maintain continuity of care and the efficient and appropriate use of medical resources.
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> **Prior Authorization** - Aetna Better Health of Louisiana must pre-approve certain medically necessary services before a member can receive them. We call this prior authorization. This means that providers must get permission from Aetna Better Health of Louisiana to provide certain services. These services must be covered by the member's benefit plan.

**Referral Policy:** Referrals are not required for any covered service.

**Prior Authorization Policy:** Aetna Better Health must pre-approve some services before a member may receive them.

Except for family planning and emergency care, all out-of-network services require pre-approval. Members may have to pay for services if the provider does not get pre-approval for services that:

- Are given by an out-of-network provider
- Require pre-approval
- Are not covered by Aetna Better Health of Louisiana

**All services by providers that are not in our network need pre-approval.**

**Quick Reference to the services that require Prior Authorization:**
http://www.aetnabetterhealth.com/louisiana/assets/pdf/providers/ProviderManual-LA.pdf .

**Prior Authorization Questions:** Member Services is available 24 hours a day, 7 days a week. Just call **1-855-242-0802** or fax requests to **1-844-227-9205.**

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## Healthy Blue

**Quick Reference**:
https://providers.amerigroup.com/QuickTools/Pages/PrecertificationLookup.aspx > Select "Louisiana" Market > Select "Medicaid/SCHIP/Family Care" Line of Business.

**Applicable Definitions:**

> **Referral** is the directing of a member/patient to a medical specialist by a provider (usually a PCP) or Healthy Blue care coordinator/case manager.
>
> **Prior Authorization, termed "precertification"** by Healthy Blue, is the process whereby Healthy Blue determines the medical necessity and appropriateness of a given coverage request *before* the service is provided.

**Referral Policy:** Referral is not required to see an in-network specialist. However, some specialty and other services require precertification. See above quick reference for complete precertification information. Healthy Blue encourages communication between PCPs and treating specialists for purposes of coordination of care; however, there are no specific guidelines that require specific documentation be exchanged.

**Prior Authorization Policy:** Refer to the Precertification Guidelines grid on pages 62-80 of the Provider Manual
https://providers.amerigroup.com/ProviderDocuments/LALA_CAID_ProviderHandbook.pdf

**Referral and Prior Authorization Questions:**
Provider Services Phone: 844-521-6942, Fax: 800-964-3627

## AmeriHealth Caritas Louisiana

**Quick Reference**:
http://www.amerihealthcaritasla.com/provider/resources/priorauth/index.aspx

**Applicable Definitions**

**Referral:** The process followed by a PCP and/or Specialist when needed medical care or services cannot be provided within the primary care office or when services outside the scope of his/her expertise are indicated.

**Prior Authorization**: A determination made by AmeriHealth Caritas Louisiana or its representative to approve or deny payment for a service or course of treatment of a specific duration and scope prior to the provider's initiation of the requested service. The Prior Authorization process often involves a nurse and/or physician reviewing the request for medical necessity. This process may be initiated by contacting AmeriHealth Caritas Louisiana Utilization Management Department.

**Referral Policy:** Referrals are for specialty services  However, we encourage PCPs and specialists to coordinate member care.

**Prior Authorization Policy:** Prior authorization is required for out-of-network services. When out-of-network services are needed, the network provider should contact the Utilization Management Department for Prior Authorization. AmeriHealth Caritas Louisiana's Utilization Management Department Telephone Number is 1-**888-913-0350**. If a non-Participating Provider is prior authorized, that provider must obtain a Non-Participating Provider number in order to be reimbursed for services provided. The form for obtaining a Non-Participating Provider number can be obtained by calling Provider Services at 1-**888-922-0007.**

For a comprehensive list of services requiring prior authorization, see http://www.amerihealthcaritasla.com/provider/resources/priorauth/index.aspx

**Medication requiring prior authorization**

Drugs requiring prior authorization (PA) or having any other restrictions are identified in the AmeriHealth Caritas Louisiana printable formulary (PDF) and through the searchable formulary. Direct all questions about pharmacy services to PerformRx Provider Services at 1-800-684-5502 or fax to 1-855-452-9131.

**Prior Authorization Questions:**
AmeriHealth Caritas Louisiana Utilization Management Department Phone: 888-913-0350, Fax: 866-397-4522 . The AmeriHealth Caritas Louisiana Utilization Management Department standard hours of operation are 8 am – 5 pm, Monday through Friday; however, staff is available 24 hours a day 365 days a year for expedited prior authorization requests.

**Provider Questions:**
ACLA Provider Services Phone: 1-877-922-0007

## Louisiana Healthcare Connections (LHCC)

**Quick Reference:** http://www.louisianahealthconnect.com/for-providers/prior-authorization/

**Applicable Definitions**

> **<u>Referrals</u> are paper documents that originate with one provider (not the health plan) indicating that their permission is granted for the member (their patient) to see another provider, usually a specialist.**
>
> **<u>Prior Authorization</u> is an approval from the health plan (not the provider) for a service that the member needs. A prior authorization means that the approval is needed prior (before) the service is provided. (**Some services require prior authorization from Louisiana Healthcare Connections in order for reimbursement to be issued).

**Referral Policy: Referral is not required to see an in-network specialist.** As promoted by the Medical Home concept, PCPs should coordinate the healthcare services for LHCC members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, referrals *are not* required. To better coordinate a member's healthcare, Louisiana Healthcare Connections encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

**Prior Authorization Policy:** Some services require prior authorization from LHCC in order for the provider to be reimbursed. All out-of-network services require prior authorization, excluding family planning, emergency room, and routine radiology.

- Download the latest Inpatient and Outpatient PA Request forms: www.LaHealth.CC/PA
- For even faster, easier PAs, use our secure provider portal: Provider.LouisianaHealthConnect.com
- To check if a service requires prior authorization, use the online screening tool: www.LaHealth.CC/PriorAuth. Or refer to the Benefit Explanation and Limitations Grid in the Provider Manual: www.LaHealth.CC/ProviderManual

Medical Management hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). After normal business hours, staff is available to answer questions about prior authorization.

Prior authorization should be requested at least seven calendar days before the scheduled service delivery date or as soon as need for service is identified. The Provider should contact the UM department via telephone, fax or through the secure provider portal with supporting clinical information to request an authorization. The fax number is **1-877-401-8175**.

**Referral and Prior Authorization Questions**
Call 1-866-595-8133 and ask to speak to Prior Authorization.

## UnitedHealthcare (UHC)

**Quick Reference:**
[www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/PriorAuth/LA_PriorAuthDocument_PCA15905.pdf](www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/PriorAuth/LA_PriorAuthDocument_PCA15905.pdf)

**Applicable Definitions**

> **Referral** is the directing of members for services or procedures to be provided by another provider, typically a specialist, when those services are outside the scope of service for the directing provider. Typically referrals are given by the member's primary care physician.
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> **Prior Authorization** is an approval from UnitedHealthcare for a service or procedure prior to the service being rendered for a member that is deemed medically necessary and meets the Louisiana Medicaid regulations as a covered service.

**Referral Policy:** Referral is not required for any covered service.

**Prior Authorization Policy:** UnitedHealthcare requires prior authorizations for certain covered services. For a list of services that require prior authorization, refer to the quick reference link provided above. All physicians, facilities and agencies providing services that require **Medical** prior authorization should call the Prior Authorization Department at **866-604-3267** (available 24/7), in advance of performing the procedure or providing service(s) to verify UnitedHealthcare has issued an authorization number.

A Primary Care Physician or **Medical** specialist can telephone or fax a prior authorization request to UnitedHealthcare Community Plan. A physician or pharmacist reviews all cases in which the care does not appear to meet criteria or guidelines which are adopted by UnitedHealthcare Community Plan's Medical Policy Committee. Decisions regarding coverage are based on the appropriateness of care and service and existence of coverage. Practitioners or other individuals are not rewarded, nor receive incentives for issuing denials of coverage or service. Responses to requests will be answered within two business days for standard requests, and within 72 hours for expedited requests.

**Medical Prior Authorization Questions:**
Intake/Prior Authorization Team Phone: 866-604-3267, Fax: 877-271-6290 (Available 24/7)