BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual

Section D

Referral Notification Program

Important Notes:
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health. These specific requirements will be noted with the plan/ network name. If a plan/network name is not specifically listed or the "Plan" is referenced, the information will apply to all products.

Capitated Medical Groups - Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated Medical Group are subject to that entity's procedures and requirements for the Plan's provider complaint resolution.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
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1 Referral Notification Overview

The referral notification process is a mechanism by which a primary care provider can refer the member for care and services beyond the PCP's scope of practice to specialty care providers. This section provides clarification on the referral process for Blue Cross and Blue Shield of Texas **Plan** members.

Note: *Refer to the "Behavioral Health" section of this Manual for information on referral information for behavioral health services.*

2 When to Request Referrals

Each **Blue Essentials, Blue Advantage HMO, Blue Advantage Plus, Blue Premier and MyBlue Health** member ***must*** select a PCP who is responsible for managing all aspects of the patient's care, including referrals to specialty care providers for services beyond the PCP's scope of practice. Referrals must be made to health care providers who participate in the member's **same** provider network, when available, prior to the patient receiving services.

The referral ***must*** be initiated by the PCP and must be requested through Availity® Authorizations & Referrals tool before the service is rendered.

Exceptions:

- Participating OBGyn physicians can directly manage and coordinate a woman's care for gynecological and obstetrical conditions, including obtaining referrals through Availity Authorizations & Referrals tool for gynecologically related specialty care and testing to other participating **Plan** health care providers who participate in the same Provider Network as the member's **Plan** PCP.
- **Blue Premier Access** is considered an "open access" HMO plan where no PCP selection or referrals are required when the covered person uses in-network providers in the **Blue Premier** network.
- Upon admission to an inpatient facility, (e.g. hospital or skilled nursing facility), a participating physician other than your PCP may direct and oversee your care.

If a participating provider must direct the patient to an out-of-network physician or professional provider, a referral must be authorized by the **Plan's Medical Management Department** before the service is rendered.

3 Important Information

The following outlines important information about **Plan** referrals

- Approval is required for all out-of-network/ plan referrals by the **Medical Management Department** at the **Plan**.
- A PCP may not refer to himself/herself as a specialty care physician or professional provider when treating the member who is already on his/her PCP list.
- **Peer Clinical Review** — If information received in the out-of-network referral notification process does not satisfy established criteria, the case will be referred to a **Plan** Physician Reviewer for review. Additional medical information may be necessary in these cases.
- **Notification** — The **Plan** will mail letters to the specialty care/servicing physician or professional provider and the **Plan** member. This notification will be sent upon completion of the initial referral process, upon completion of a referral extension or upon denial of an initial referral or extension.
- If the specialty care physician or professional provider determines that a **Plan** member needs to be seen by another **Plan** specialty care provider, the **Plan** member ***must*** be referred back to the member's PCP.

Note: *The specialty care physician or professional provider cannot refer on to other specialty care physicians or professional providers. (**EXCEPTION:** participating OBGyn physicians can directly manage and coordinate a woman's care for gynecological and obstetrical conditions, including obtaining referrals for gynecologically related specialty care and testing to other participating **Plan** health care providers who participate in the same Provider Network as the **Plan** member's* PCP.

- **Self-Directed Care**
  - If a **Blue Essentials, Blue Advantage HMO, Blue Premier or MyBlue Health** member is treated by a **Plan** physician or professional provider other than the PCP or a participating OBGyn without a referral, the service provided will not be covered by the **Plan**.
  - A **Blue Advantage Plus HMO** member can choose to self-direct their care under their out-of-network benefits at a higher member cost share.
  - **Blue Premier Access** is considered an "open access" HMO plan where no PCP selection or referrals are required when the covered person uses in-network providers in their applicable HMO network.
- **Benefit Decision**
  The decision to provide treatment is between the patient and the PCP or specialty care provider. The **Plan** determines what is covered and payable under the benefit plan.

Note: *Referral confirmation is not verification and does not guarantee payment. Payment is subject, but not limited to eligibility, contractual limitations, and payment of premium on the date(s) of service.*

4 Submitting Referral Requests

Plan referrals may be requested by either the patient's primary care providers or the backup PCP**.** Refer to the detailed information and instructions for submitting referrals in **Section C Authorization Process** of this **Blue Essentials, Blue Advantage HMO, Blue and MyBlue Health Provider Manual.**

Please have the following information readily available when initiating a referral notification:

- Patient's full name
- Member ID number
- Policy or group number
- Anticipated date(s) of service
- Diagnosis (ICD-10 code)
- Procedure(s) anticipated (CPT® or HCPCS code)
- Referring physician or professional provider name
- Specialty care physician or professional provider name, NPI and phone number

Referrals can be submitted as follows:

- **Online Via Availity Authorization & Referrals**
  Availity's Authorizations & Referrals tool (HIPAA-standard 278 transaction) allows the electronic submission of referral requests managed by BCBSTX. Additionally, providers can also check status on previously submitted requests and/or update applicable existing requests. The tool provides a referral confirmation number and notification letters are automatically generated to the specialty care provider and the **Plan** member. Submission information can also be found on the Availity Authorization & Referral page on the provider website.

  If you are not yet registered with Availity, sign up at Availity at no charge. If you need registration assistance, contact Availity Client Services at **800-282-4548**.
- **Via Phone**
  Contact Medical Care Management Department at 800-441-9188 from 6 a.m. - 6 p.m. (CT), Monday through Friday or 9 a.m. – 12 noon (CT) on weekends and legal holidays. After hours and overflow call are answered electronically and are returned within 24hours in the order in which they are received**.**
- **Via Fax**
  Submit requests to **800-252-8815** or **800-462-3272**

Notification letters for phone or fax are sent to the member and the SCP.

5 Request for Out-of-Network Referrals When no In-network Provider Is Available or For Continuity of Care

The **Plan's** Medical Management ***must*** review all requests for Out-of-Network referrals ***before*** a **Plan** member receives care. The PCP must contact the **Plan** Utilization Management Department at the applicable number listed below to request consideration of an Out-of-Plan or Out-of- Network referral. The request will be reviewed, and the **Plan** Utilization Management Department will forward a determination letter to the Out-of-Plan or Out-of-Network physician or professional provider.

If the out-of-network provider needs to perform or refer a patient for a certain service that requires prior authorization or is applicable to an optional recommended clinical review, they must get an approval from Medical Management. The referral for the out-of-network services does not apply to the services requiring prior authorization or an RCR.

6 Blue Advantage Plus HMO (Point of Service benefit plan) Out-of-Network Referral When an In-Network Provider is Available

Before referring a **Blue Advantage Plus HMO (Point of Service benefit plan)** enrollee to an out-of-network provider for non-emergency services, if such services are also available through an in-network Blue Advantage HMO provider, as a participating network provider, you must complete the appropriate form below:

- Out-of-Network Care - Enrollee Notification Form for Regulated Business (use this form if "TDI" is on the member's ID card)
- Out-of-Network Care - Enrollee Notification Form for Non-Regulated Business (use this form if "TDI" is not on the member's ID card)

As the referring network physician, you must provide a copy of the completed form to the enrollee and retain a copy in his or her medical record files. Use of this form is subject to periodic audit to determine compliance with this administrative requirement outlined in this provider manual *Section G – Quality Improvement Program/Principles of Medical Record Documentation.*

Please note: The **Out-Of-Network Enrollee Notification Form is not applicable for Out-of-Plan or Out-of-Network referrals due to network inadequacy or continuity of care.** In these cases, the referring network physician should contact the Medical Management Department at the applicable number below for consideration of approval for out-or-network referral or authorization

Medical Management Department

- Blue Essentials Member: **855-896-2701**
- Blue Advantage HMO: **855-896-2701**
- Blue Premier: **800-876-2583**
- MyBlue Health: **855-896-2701**

Hours: 6 a.m. – 6 p.m., CST, Monday-Friday and non-legal holidays and 9 a.m. to 12 noon (CST), Saturday, Sunday and legal holidays. Messages may be left in a confidential voice mailbox after business hours.

If the Out-of-Network/Plan specialty care physician or professional provider determines that additional care is needed, the provider must obtain authorization from the **Plan** Utilization Management Department for the additional care. All specialty physicians or professional providers are expected to inform the **Plan** member's PCP of their findings.

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Please note that checking of eligibility and benefits information, and/or the fact that any pre-service review has been conducted, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.