BlueCross BlueShield of Texas

Blue Choice PPO℠ and Blue High Performance Network®
Provider Manual

Section D
Referral Notification

Important Note: Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge℠, EPO and the Federal Employee Program®. 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.

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1 Referral Notification Overview

Referral notification determines the level of benefits the patients may receive under the direction of their network health care providers. This section provides clarification on the referral process for medical services for Blue Cross and Blue Shield of Texas **Plan** members.

Note: Refer to the "Behavioral Health" (Section I) of this Provider Manual for information on referral notifications for behavioral health.

2 When to Request Referral

Plan members (including **Blue Choice PPO℠**, **Blue Edge, BlueHPN®, Exclusive Provider Organization** and the **Federal Employee Program®**) require referrals only when a referral to an out-of-network health care provider is necessary due to network inadequacy or continuity of care. BlueHPN and EPO plans only have coverage for in-network providers. To receive benefits, referrals to out-of-network providers for BlueHPN and EPO members must be authorized by the **Medical Management Department**.

The **Plan** referring provider, servicing provider or member must contact the Plan's Medical Management Department to request an out-of-network referral authorization. For requests that are approved, the **Plan's Medical Management Department** will forward a determination letter to the out-of-network provider.

3 Important Information

The following outlines important information about the Plan referral notifications 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 BCBSTX Physician Reviewer for review. Additional medical information may be necessary in these cases.

- **Emergencies –** Physician or professional providers must admit patients to a participating facility unless an emergency situation exists that precludes safe access to a Plan facility or if the admission is approved by BCBSTX for a non-Plan facility because of extenuating circumstances. When appropriate, the patient should be transferred to a Plan facility as soon as medically possible.
  Note: *For behavioral health emergency information, refer to the "Behavioral Health" (Section I) of this Provider Manual.*
- **Benefit Decision** — The decision to provide treatment is between the patient, the PCP and/or the **Plan** health care provider or the out of Plan healthcare provider if the member has out of network benefits. BCBSTX determines what is covered and payable under the benefit plan.
- Referral Notification **is not a verification** and does not guarantee payment. Payment will be determined after the claim is filed and is subject to the following:
  - Eligibility
  - Other contractual limitations, including, but not limited to:
  - Cosmetic procedures
  - Failure to prior authorize services
  - Limitations contained in riders, if any
  - Claims Processing Guidelines
  - Payment of premium for the date on which services are rendered (Federal Employee Participants are not subject to the payment of premium limitation).

4 Submitting Referral Requests

Refer to the detailed information and instructions on submitting referrals in **Section C Authorization Process** of this Blue Choice and Blue High Performance Provider Manual**.**

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

- Patient's full name
- BCBSTX member ID number

- Policy or group number
- Anticipated date(s) of service
- Diagnosis (ICD-10 code)
- Procedure(s) anticipated (CPT® or HCPCS code)
- Referring health care provider name and NPI
- Specialty care health care provider name, NPI and phone number

Referrals can be submitted as follows:

- **Online Via Availity® Authorizations & Referrals**
  Availity Authorization & Referrals tool (HIPAA-standard 278 transaction) allows the electronic submission of referral requests handled by BCBSTX. Additionally, providers can also check status on previously submitted referrals and/or update applicable existing referrals. The tool provides a referral confirmation number. 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 at **855-896-2701** 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 **800-252-88**15 or **800-462-3272**

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

5 Out-of-Network Provider Referral When In-Network Provider is Available

Prior to referring a **Plan** enrollee to an out-of-network provider for non-emergency services, if such services are also available through an in-network **Plan** 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 a referring network physician, you must provide a copy of the completed form to the enrollee and retain a copy in his or her medical records files.