BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual - Referral Notification Program

Please Note

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 plan/network specific requirements will be noted with the plan/network name.
If a plan/network name is not specifically listed or "**Plan**" is referenced, the information will apply to all HMO products.

In this Section

The following topics are covered in this section:

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Referral Notification Overview

The referral notification process is a mechanism by which a primary care provider can refer his or her members for care and services 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.*

Capitated Medical Group - Important Note

Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral, prior authorization or recommended clinical review 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.

Who Requests Referrals?

Plan referrals may be requested by either the patient's primary care provider or backup primary care provider.

When is a Referral Necessary?

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 health care providers. Referrals must be made to health care providers who participate in the member's **same** Provider Network. Authorization for out-of-network providers is granted only when a participating provider is not available. **Plan** members require a referral before the patient receives services from an in-network specialty care provider. This referral ***must*** be initiated by the PCP and must be obtained through Availity® Authorizations & Referrals tool before the service is rendered.

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.

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When is a Referral Necessary, cont.

Exceptions:

- Participating OBGyn physicians have the ability to 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 plans where no PCP selection or referrals are required when the covered person uses in-network providers in the **Blue Premier** network.

Important Information About the Referral Notification Program

The following outlines important information about the **Plan's** Referral Notification Program.

- **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 an **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.
- **Referrals to Specialty Care Physicians or Professional Providers** — Referrals to specialty care physicians or professional providers, except OBGyns, ***must*** be initiated by the member's **Plan** PCP to participating **plan** physician or professional providers within the member's Plan's same Provider Network. A **Plan** Utilization Management Department approval is required for all out-of-network/ plan referrals. 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.

Important Information About the Referral Notification Program, cont.

Refer to the detailed information and instructions in Section C of the **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual** which discusses the Authorization Process for referrals**.** The Availity Authorizations & Referrals tool provides a referral confirmation number and notification letters are automatically generated to the specialty care physician or professional provider and the **Plan** member.

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 have the ability to 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.*

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Information Necessary for Referral Notification

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 code)
- Referring physician or professional provider name
- Specialty care physician or professional provider name, NPI and phone number

Notification Procedure Through Availity Authorizations & Referrals

Availity's Authorizations & Referrals tool (HIPAA-standard 278 transaction) allows the electronic submission of inpatient admissions, select outpatient services and referral requests handled by BCBSTX. Additionally, providers can also check status on previously submitted requests and/or update applicable existing requests.

How to access and use Availity Authorizations & Referrals tool:

1. Log in to Availity
2. Select Patient Registration menu option, choose Authorizations & Referrals, then **Referrals***
3. Select Payer BCBSTX, then choose your organization
4. Select a Request Type and start request
5. Review and submit your request

* Choose **Authorizations** instead of Referrals if you are submitting an authorization request.

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 **1-800-282-4548**.

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Notification Procedure by Fax or Phone

Providers may also initiate ***prior*** referral notifications by fax or phone:

Method	Action by PCP	Action by BCBSTX
Telephone	**Medical Care Management Department:** Call **1-800-441-9188** between 6:00 a.m. and 6:00 p.m. (CST), Monday through Friday; 9:00 a.m. and 12 noon (CST) on weekends and legal holidays. After hours and overflow calls are answered electronically. These calls are returned within 24 hours in the order in which they are received.	Sends notification letters to the SCP and member.
Fax	Fax request to: **1-800-252-8815** *or* **1-800-462-3272**	Sends notification letters to the member and SCP.

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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-Plan or Out-of-Network referrals ***before*** a **Plan** member receives care. The PCP must contact the **Plan** Utilization Management Department at the applicable number listed on the next page 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 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 the RCR.

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 on the next page for consideration of approval for out-or-network referral or authorization.

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Blue Advantage Plus HMO (Point of Service benefit plan) Out-Of-Network Referral When an In-Network Provider Is Available, cont.

Medical Management Department

Blue Essentials Member: **1-855-896-2701**

Blue Advantage HMO: **1-855-896-2701**

Blue Premier: **1-800-876-2583**

MyBlue Health: **1-855-896-2701**

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 physician or professional 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.