Blue Choice PPO℠ and Blue High Performance Network® (BlueHPN)® Provider Manual - Referral Notification Program

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 "Plan" is referenced, the information will apply to all PPO products.

In this Section

The following topics are covered in this section:

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Referral Notification Program Overview

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

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

When is a Referral Necessary

Plan members *(including Blue Choice PPO, BlueEdge, BlueHPN, Exclusive Provider Organization (EPO) and the Federal Employee Program Plan)* require referrals only when a referral to an out-of-network health care provider is necessary due to network inadequacy or continuity of care. If a network physician or professional provider must direct the patient to an out-of-network, health care provider due to network inadequacy or continuity of care, a referral must be authorized by BCBSTX ***prior*** to the services being rendered.

Important Information About the Referral Notification Program

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

- **Emergencies**

  Physicians or professional providers must admit patients to a participating **Plan** 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. BCBSTX determines what is covered and payable under the benefit plan.

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Important Information About the Referral Notification Program, cont.

Note: 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).*

Information Necessary for Referral Notification

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

- 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 code)
- Referring health care provider name and NPI
- Specialty Care health care 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:

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

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 Procedures by Fax or Phone

Referral notification can also be initiated by:

Method	Action by PCP	Action by BCBSTX
Fax	Fax request to: **1-800-252-8815 or** **1-800-462-3272**	Sends notification letters to the member and the specialist provider (SCP).
Phone	Call **1-855-896-2701** between 6 a.m. and 6 p.m. (CST), Mon – Fri, 9 a.m. - 12 noon 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

Referrals Out-of-Network/ Plan Procedure

A referral to an out-of-plan or out-of-network health care provider which is necessary due to network inadequacy or continuity of care must be reviewed by the BCBSTX Medical Management ***prior*** to a BCBSTX patient receiving care.

The **Plan** referring physician or professional provider must contact the **Plan's** Medical Management Department (see next page) to request an out-of-plan or out-of-network referral authorization. For requests that are approved, the **Plan's** Medical Management Department will forward an approval letter to the out-of-plan or out-of-network physician or professional provider.

Requests for out-of-plan or out-of-network referrals should be directed to:

BCBSTX Medical Management Department
1-855-896-2701

- Hours: 6 a.m. – 6 p.m. (CST), M-F 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 health care provider determines that additional care is needed and/or that care requires prior authorization, the health care provider must obtain additional approval from the **Plan's** Medical Management Department.

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Out-of-Network Referral When An 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.