

# **Section 5**

## **Referral/Authorization Process**

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# Section 5

## The Referral Process

In an effort to reduce administrative burdens, while still requiring the coordination of care, CDPHP redesigned its referral process and removed the use of referral numbers. Members in some products (see chart below) are required to designate a primary care physician who will coordinate their care, and specialists are still required to provide findings and make recommendations to the referring primary care physician where required; however, CDPHP no longer requires the use of a 15-character referral number. It is expected that primary care physicians and specialists communicate referrals in the method that suits their business practices. Where required, the specialist will only need to report the referring physician's name and NPI # on their claim form in field 17 (loop 2310 on the 837 HIPAA transaction).

### Referral Requirement Guideline

Product	PCP Designation Required	Referring Phys. NPI # Required on Spec. Claim
HMO	Yes	No (referral not required)
Medicaid Select Plan	Yes	Yes
Medicaid HARP	Yes	Yes
Medicare Advantage Individual/Group	Yes	Yes
Medicare PPO	No	No
Child Health Plus	Yes	Yes
PPO and High Deductible PPO	No	No
EPO and High Deductible EPO	No	No
Self-insured Plans	As determined by the employer.	As determined by the employer.
Essential Plan	Yes	Yes

### Important Information for Referring Physicians and Specialists

- Primary care physicians are required to coordinate their members' care, and – when a referral is required – communicate to the specialist clinical issues and nature of the referral, as well as what they seek from the referral.
- Referrals must be made to a CDPHP participating provider. (Refer to the Find-A-Doc on [www.cdphp.com](http://www.cdphp.com) for the most up-to-date listing of participating providers.)
- Document all clinical referrals in the patient's record.
- The referring physician may communicate the referral along with their NPI # to the specialist in any fashion that works for the practice (e.g., calling the specialist, faxing, or e-mailing a script or note to the specialist, giving an office referral to the patient to bring to the specialist, etc.).
- The referring physician should determine the length of treatment and/or number of visits and indicate this in the referral. If the specialist feels that additional visits are required beyond those requested by the referring physician, it is expected that communication occur between the medical professionals to determine the required care. The discussion should be documented in both physicians' records.
- If the specialist is treating a member for a current episode of care and discovers a new diagnosis that requires medical attention, the specialist must contact the PCP and discuss the best course of action to meet the member's medical needs. The discussion should be documented in both physicians' records. As long as agreement is reached that the specialist should treat the new condition, no further action is necessary.
- Practitioners and providers will follow CDPHP medical policy.

- On-call and covering CDPHP participating physicians may refer on behalf of the member's PCP, or other approved referring physician.
- PCPs, orthopedic specialists, neurosurgeons, physiatrists, neurologists, rheumatologists, hand surgeons, vascular surgeons, pulmonologists, and podiatrists may refer for physical therapy services.
- After seeking services from a specialist, if a member requests another referral to a different physician of the same specialty, the PCP must agree to issue another referral.
- When a member presents in the specialist office, you should verify the member's eligibility and that their product coverage requires a PCP referral for specialist services. If a referral is required, ask the patient who referred them for the services, and report the referring provider name and NPI # in field 17 of the CMS-1500 form (loop 2310 of the 837 HIPAA transaction).

### **Important Information Regarding the Member**

- Members select a PCP who provides all routine care. Members with the PPO, HDPPPO, EPO or HDEPO products are not required to select a PCP or OB/GYN of record.
- Female members may seek care from their OB/GYN without a referral from their PCP.
- The OB/GYN may refer for the following services:
  - Evaluation of breast mass
  - GYN oncology
  - Infertility/gynecological endocrinology
  - Urological evaluation for infertility of patient's spouse (one visit only)
  - GYN dermatological conditions
  - Urological conditions
  - High-risk pregnancy (refer to perinatologist)
  - Genetic counseling
  - Termination of pregnancy

### **Important Information Regarding Services**

- Emergency medical conditions, radiology, high-tech radiology, laboratory services, and routine eye exams do not require a referral.
- CDPHP will allow one follow-up visit after a member is treated in the emergency room. The follow-up visit must be submitted with "ET" modifier on the claim. This visit must occur within 10 business days of the emergency visit.
- A complete list of services requiring prior authorization, titled Prior Authorization Guideline, is available on the secure provider portal of [www.cdphp.com](http://www.cdphp.com).
- Certain behavioral health services in Medicaid–Select Plan and Medicaid–HARP require prior authorization by calling the Behavioral Health Access Center at (518) 641-3600 or toll free at 1-888-320-9584. (A complete list of services requiring prior authorization, titled Prior Authorization Guideline, is available in the secure area of [www.cdphp.com](http://www.cdphp.com).)
- CDPHP complies with all specific time frames for decision making and notification under the law.

### **Important Information Regarding Claims**

- For inpatient services from a participating provider, prior authorization is not required. Notification needs to take place once a patient is admitted to a facility. All non-participating providers need to follow the prior authorization process by faxing the CDPHP resource coordination department at (518) 641-3207.

# Prior Authorizations

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For in-network services that require prior authorization (per the CDPHP prior authorization guideline), it is the responsibility of the CDPHP practitioner to obtain prior authorization. Failure to comply with this policy will result in disallowance of reimbursement. If the member has not agreed in writing to pay for the services prior to provision of the services, the CDPHP practitioner may not bill the member. The services provided are subject to the limitations and exclusions of the member's certificate.

For members without an out-of-network benefit, CDPHP strives to keep all referrals within our network of participating practitioners. However, it is sometimes necessary to seek services outside of the CDPHP network; in those cases, prior authorization must be obtained from the Resource Coordination Department at CDPHP.

In the event that a covered health service cannot be provided by a practitioner participating in the CDPHP network, the member shall be referred to another practitioner for the necessary care. For members without an out-of-network benefit, CDPHP will not pay for health services that have been provided by non-participating practitioners unless the health services have been pre-authorized. The only exception is in an emergency situation. Failure of the participating CDPHP practitioner to obtain prior authorization will result in disallowance of reimbursement of the participating practitioner's services. The services provided will be subject to the limitations and exclusions of the member's certificate.

## Prior Authorization Guideline

The prior authorization guideline outlines those services that require prior authorization through the CDPHP resource coordination department. For the most current version of the prior authorization guideline and resource coordination policies, please go to Volume II of this manual in the secure provider portal of [www.cdphp.com](http://www.cdphp.com).

Please be aware that the guideline does not reflect those instances in which it is the member's responsibility to seek prior authorization. Coverage for a service is subject to the member's eligibility, specific contract benefits, and CDPHP Resource Coordination policy. Requests for a service that does not meet criteria outlined in CDPHP resource coordination policies or for an extension beyond what has been approved by CDPHP, should be directed to the provider services department at (518) 641-3500 or 1-800-926-7526, prompt #4 for eligibility related to prior authorization.

When requesting prior authorization, please provide the following information:

- Member name and ID number
- Service being requested (include CPT/HCPCS codes)
- Diagnosis
- Name of provider ordering the service
- Name of the provider rendering the service.
- Clinical documentation to support the request for medical necessity.