

Frequently Asked Questions about Referrals & Prospective Reviews

Q1: *What is the difference between terms such as Referral, Pre-Authorizations, PreCertification, Prospective Review, Benefits Analysis, etc.?*

A: Health plans use a variety of terms that often mean the same thing. And sometimes, the same term may mean different things to different health plans. Differences in terminology create a lot of confusion.

There are two basic communication processes that providers use to notify health plans about services and to get information back from them. Below is a description of each of those two communication processes along with the terms that are typically used.

Referral –this is the communication process where a patient’s Primary Care Provider (PCP) notifies the health plan that the patient is being referred to a specialist or a facility for a service(s) related to a health condition. Referrals apply primarily to managed care patients. Communication with a health plan is IN ADDITION to the communication that should take place between a patient’s primary care giver and a specialist. Practitioner communication is a key component of good clinical practice.

Different health plans have different requirements for referrals.

- Some health plans don’t require referrals at all, or only require them for certain services.
- Some health plans just require notification about a referral in order for the related claim to pay.
- Other health plans require that referrals be approved by them prior to service delivery in order for a related claim to pay.

Check the referral grid for requirements by health plan.

There are a variety of different terms that are used for the referral process. These terms relate to health plan specific processing steps and requirements. These terms include, but may not be limited to, **referral, referral request, referral notification, referral authorization.**

Prospective Review – this is the communication process where the facility/provider (which may be a PCP, a specialist or a hospital) asks the health plan to determine whether the to-be-delivered procedures/services, a) satisfy medical review criteria, and b) are covered by the patient’s benefits. Prospective Reviews apply to all patients as described on the prospective review grid.

For certain services, some health plans require providers to request a prospective review prior to service delivery in order for the related claim to pay. Once a prospective review is completed, these health plans will guarantee payment for specified services that are

delivered to a patient within a defined period of time. This type of prospective review is typically called a **pre-authorization or a prior-authorization**.

Though increasingly rare, some health plans require providers to request approval for a specific number of inpatient days prior to patient admission in order for the related claim to pay. This type of prospective review is typically called a **pre-cert or a pre-certification**.

Other health plans will perform a prospective review upon request, but do not require providers to get a prospective review. Upon request, the health plan will tell the provider whether the services meet their medical criteria and whether the services are covered by the patient's benefit. However, they will not guarantee payment prior to service delivery. These health plans want to make sure that the patient remains eligible for coverage at the time of service delivery. This type of prospective review is typically called a **Benefits Advisory**.

Note: There are situations where a PCP will refer a managed care patient to a specialist/facility for a service that requires pre-authorization by a health plan. Depending upon the health plan and the specific service, both a referral and a prospective review may be required. In those cases, the PCP must initiate the referral and the specialist/facility must request a pre-authorization.

There may be slight differences in these definitions between different health plans. Feel free to check with any health plan for their specific definitions and for when pre-certifications are required.

Q2: When a patient is being referred for inpatient surgery, are two referrals required -- one for the surgeon and one for the facility?

A: Only one referral is ever required, and only for managed care patients. Check the Referral grid to see when a referral is required. If a referral is required, the PCP only needs to notify the health plan that the patient is being referred to a specialist for possible surgery. A separate referral for the hospital is not needed and should not be generated.

Some health plans require a prior-authorization for some surgeries, as described in the Prospective Review grid. The prior-authorization may be in addition to the referral. The prior-authorization is the responsibility of the rendering facility/physician.

Q3: Upon their discharge from the hospital, patients are sometimes referred for treatment in an outpatient setting. This referral may be a follow-up for an inpatient consult or may be to a specialist who did not see the patient in the hospital. Must the referral for the outpatient services be initiated by the patient's PCP in order for it to be valid with the health plan?

A: The referral grid lists those services for which a referral is required. Unless otherwise indicated on the grid, referrals for these services must be initiated by the patient's PCP to

be paid at the highest benefit level. The patient has the responsibility for getting a referral from the PCP.

A referral is not required for follow-up outpatient care provided by the specialist if fees for the care are included as part of the global fee/days. ('Global fees/days' is a specified rate/time period for delivering care from an initial procedure through normal, uncomplicated follow-up. See Medicare Physician Fee Schedule Database for more specifics.) A referral is not required for incidental supplies that may be used in the follow-up visit.

Q4: *Specialists are sometimes called into the emergency room (ER), as a consulting physician, to treat a patient. The patient is then instructed to see that specialist in their office for follow-up care as an outpatient. Is a referral required for the ER treatment provided by a consulting physician and/or for the office follow-up? If so, must the referral be initiated by the patient's PCP for it to be valid with the health plan?*

A: Referrals are not required for services provided by a consulting physician specialist in the ER as long as they are coded with a revenue code of 450, a place of service code of 23, and CPT codes in the range 99281-99285. (Services provided by specialists should be coded using the appropriate ER code and not a consultation code.) Benefits will be processed to the highest benefit level. Deductible and co-payments may apply.

Check the Referral grid to see when a referral is required for follow-up care. A referral is not required if the physician will not be submitting a claim to the health plan, e.g., the follow-up visit is considered part of the service delivered in the ER. (A referral is not required for incidental supplies that may be used in the follow-up visit.)

Health plans encourage the ER to refer the patient to their PCP for follow-up care that is not provided by an ER consulting physician as part of the ER services.

A referral from the patient's PCP is required for care which is additional to the service delivered in the ER, whether it is provided by the ER consulting physician or any other physician referred to by the ER. The patient has the responsibility for getting a referral from the PCP.

Q5: *If a PCP refers a patient to a surgeon and selects 'Evaluate & Treat' as the Referral Action and the surgeon determines that a surgical procedure is required, what actions should be taken so that surgery related charges are reimbursed at the highest benefit level?*

A: In this case, for surgery related charges to be reimbursed by the health plan at the highest benefit level, the PCP must issue another referral and select 'Evaluate & Treat – Surgery/Procedure if Indicated' as the Referral Action. (Some health plans may allow PCPs to notify them by phone. Check with the health plan.)

The following is a general guideline for all care providers that receive referrals -- If the procedure(s) requested on the Referral are not in agreement with the Referral Action specified on the Referral, the PCP should be contacted to issue another Referral.

Q6: *What steps can be taken so that Outpatient Diagnostic Testing services will be reimbursed at the highest benefit levels?*

A: The Outpatient Diagnostic Testing must be part of a referred service. In other words, either the patient's PCP must have referred the patient for testing or the PCP must have referred the patient to a specialist who requires testing as part of clinical care. (If the Referral Action was 'Consult Only', testing services will not be reimbursed at the highest level.)

The ordering provider must be part of the health plan's network. The ordering physician should be indicated in box 17 of the CMS 1500 or box 78 of the UB04.

The delivering provider should be part of the health plan's network or should be employed by an organization that is part of the health plan's network. For example, a radiologist who "reads" an xray does not need to be part of the health plan's network as long as the hospital/imaging center is part of the network.

Q7: *For specialty clinics (e.g., a Coumadin clinic or a wound care clinic) and for services such as lesion removal, will health plans reimburse for a facility fee as well as for professional charges?*

A: In most cases, health plans will not reimburse for a facility fee when the service can be delivered in the practitioner's office. Only appropriate professional charges will be reimbursed. Providers should check with the health plans with specific questions.

Q8: *When a provider's office and an ambulatory service center are co-located, how does a health plan differentiate between the two?*

A: In almost all cases, ambulatory service centers bill for a facility fee that is not billed when the service is delivered in the provider's office. As indicated in question Q6, health plans will typically not reimburse for a facility fee when the service can be delivered in the practitioner's office. Only appropriate professional charges will be reimbursed. Providers should check with the health plans with specific questions.

Q9: *How can Hospitals reduce their risk of non-payment for an inappropriate referral?*

A: From a hospital's perspective it is not always clear whether a physician is approved by a health plan to perform a procedure at their facility. To minimize their financial risk for

expensive procedures, hospitals usually contact the health plan for specific information about a patient's coverage. However, contacting the health plan is not always practical for the numerous less expensive procedures. Hospitals may increase their probability of being reimbursed if they indicate the referring physician in box 78 on the UB04.

Q10: *On the UB04, how should boxes 76 and 78 be used to indicate referring physician, admitting physician and rendering physician (surgeon)?*

A: Box 76 (labeled attending) should be used for rendering physician or admitting physician. If they are two different physicians, always put the rendering physician in this box.

Box 78 (labeled other) should be used for the referring physician.

Q11: *Will retroactive referrals be eligible for payment by the health plan? If so, how should they be processed by the care provider?*

A: Retroactive referrals, (i.e. the creation of a referral by a PCP AFTER the patient has been treated by another care provider), will be denied. The only exception is the case when an administrative delay held up the referral from being sent to the health plan prior to referral services being delivered to the patient. Even in this case, the need for a referral must have been **documented** in the patient's chart by the PCP prior to the patient being seen by referred-to care provider. In the case of administrative delay, the PCP should contact the health plan for instructions on processing a retroactive referral.

Q12: *When a health plans receives a request for referral or prospective review, what type of processing number, if any, do they generate? Are these numbers typically available to providers?*

A: Health plans have different practices when it comes to generating processing numbers. Some health plans generate a tracking number that *only* indicates that the request has been received. Tracking numbers and Reference numbers do not indicate approval. Other health plans generate an authorization number once the request has been approved. Authorizations assume eligibility and benefits coverage at the time of service.

The table below indicates the practice followed by each health plan.

Health Plan	Referral Request	Prospective Review Request
Aetna	Tracking #	Tracking #
Community Health Plan of Washington	Authorization #	Authorization #
First Choice	Authorization #	Authorization #
GHC	Authorization #	Reference #

Health Plan	Referral Request	Prospective Review Request
KPS	Authorization #	Authorization #
Molina	Authorization #	Authorization #
Premera	Tracking #	Reference #
Regence	Tracking #	Reference #
Uniform Medical Plan	Not Applicable	Not Applicable

Tracking numbers, Reference numbers and Authorization numbers are typically available to providers by request and/or via confirmation letters.

Q13: *When sending confirmation letters in response to prospective review requests, do health plans include CPT codes for the procedures that have been approved?*

A: On confirmation letters, health plans will only include CPT codes for approved procedures in those cases when the CPT codes were specified as part of the prospective review request.