Referral and Prior Authorization Submission Guide

Referrals – Recommendations by a Primary Care Physician (PCP) to receive care from another physician or facility

Contracted HealthPlus providers have the ability to submit referrals electronically, via the HealthPlus website. Electronic referral submission is preferred, as it ensures a timely and more efficient way to manage provider and member expectations. An alternative submission method is available for those who cannot submit electronically.

Referrals are NOT required for the following lines of Business:

- *HealthPlus PPO*
- *HealthPlus Medicare Supplemental HMO*
- *HealthPlus Medicare Advantage PPO*

The HealthPlus Web site is designed to allow for two types of referral submissions:

- ***Open Referrals:*** for Commercial HMO, MedicarePlus Advantage HMO, HealthPlus Partners Medicaid HMO, and MIChild lines of business.

- ***Limited Referrals:*** for County Health Plans, HealthPlus Options, HealthPlus Point of Service, Commercial HMO, MedicarePlus Advantage HMO, HealthPlus Partners Medicaid HMO, and MIChild lines of business.

OPEN REFERRALS

Open referrals allow in-plan/contracted specialist providers to perform necessary services to diagnose and treat a member.

Process for submission:

- The primary care physician will make the initial in-plan referral request to HealthPlus for patient's specialty care.

- A referral will remain open for a period of no less than 60 days and no more than 365 days, as determined by the primary care physician. When additional services are needed, after the requested date range expires, a new referral must be submitted for ongoing care.

- Date ranges submitted with less than a 60-day period will automatically convert to a 60-day range. Date ranges submitted with more than a 365-day period will automatically convert to a 365-day range.

- Specialists are **NOT** allowed to refer to another specialist for additional services.

Note: *requesting a specific number of visits for a service is NOT required.*

Excluded Services (include, but are not limited to):

- Services for County Health Plan enrollees
- Services for HealthPlus Options enrollees
- Services for HealthPlus Point of Service members
- Services to Tertiary Hospitals
- Behavioral health services
- Podiatry services
- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic services
- Services rendered by non-contracted and/or out-of-plan specialist provider
- Services requiring review for medical necessity
- Pharmaceuticals
- Durable Medical Equipment (DME)
- Prosthetics and Orthotics

Prior Authorization – The process of obtaining prior approval as to the medical appropriateness of care/services provided in an inpatient hospital setting, outpatient, ambulatory surgical center, or physician office. Services are reviewed against evidenced based clinical guidelines. Failure to obtain prior authorization often results in a financial penalty for the member or provider. Currently prior authorization request are submitted by fax or phone. The member's diagnosis and correct procedure codes are required when requesting a prior authorized service.

Process for Prior Authorization submission:

- In addition to the standard information required for the HealthPlus Referral Fax Sheet, the requested procedure(s) and **procedure code(s)** are also required.
- The DME P&O Request Form fax form is preferred when requesting Durable Medical Equipment requests

The following surgeries/procedures require prior authorization (the list is not all-inclusive)

- Bariatric/Weight management
- Dental services
- Durable Medical Equipment (DME)
- Orthognathic and TMJ treatments
- Frenectomy/frenulectomy/frenuloplasty
- Patatopharyngoplasty/Uvulopalatopharyngoplasty
- Elective termination of pregnancy
- Organ and tissue transplants

- Autologous chondrocyte transplant
- Experimental/Investigational services
- Infertility services
- Dorsal column stimulators/spinal cord stimulators
- Ductal lavage
- External Counterpulsation
- Left ventricular assistive devices
- Uterine artery embolization
- Cosmetic procedures

In addition to the above, **PPO members** may require prior authorization for the following consultations and procedures:

- Removal of excess skin due to weight loss.
- Heat, cold or chemical treatment of acne.
- Surgery of the jaw or gums and jaw reconstruction.
- Surgical treatments for sleep apnea.
- Autologous chondrocyte knee transplantation.
- Bone-anchored Hearing Aid.
- Services of an anesthesiologist for outpatient dental procedures.
- Genetic counseling, testing, and screening.
- Covered infertility Services.
- Varicose vein treatments.
- Robotic Image Guided Linear Accelerator (e.g., CyberKnife, Novalis Tx, Acesse).
- Clinical Trials and associated routine medical care.

PPO Inpatient Care

- Elective (non-emergent) admissions; inpatient skilled nursing; and sub-acute,
- Long-term acute and rehabilitation care.
- Mental health and substance abuse admissions, including detoxification,
- Residential day treatment (partial hospitalization) and intensive
- Outpatient/Intermediate Care.
- Skilled Nursing Facility care.
- Inpatient Hospice care.
- Clinical trials and associated routine care.

PPO Outpatient Services

- Synagis®, an injectable vaccine Specialty injectable medication
- Outpatient pulmonary rehabilitation
- Psychological testing for Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD) and Oppositional Defiant Disorder (ODD)
- All prosthetic devices and orthotic appliances
- Home Health services beyond thirty (30) visits per benefit year
- Private duty skilled Home Health Care (if Rider purchased by Subscriber's Group)
- Residential Hospice or Home Hospice beyond one hundred eighty (180) days
- Non-emergency ambulance transportation between health care facilities
- Clinical trials and associated routine medical care

PPO Durable Medical Equipment

The Durable Medical Equipment (DME) listed below *always* require Prior Authorization:

- Bone growth (Osteogenic) stimulators, electric or ultrasonic.
- CPAP (Continuous Positive Airway Pressure) or BiPAP (Bi-level Positive Airway Pressure) machine; Members must re-certify every three (3) months
- Custom made compression stockings.
- Insulin pumps

Any DME costing over three thousand dollars ($3,000) *always* requires prior authorization. Common examples include, but are not limited to:

- Chair-lift mechanisms
- Chest compression vest
- Life vests (wearable automatic cardiac defibrillators)
- Power wheelchairs
- Power operated vehicles
- Speech generating machines
- Ventilators

PPO Imaging Services, Diagnostic, and/or Therapeutic Services

- Imaging services such as Nuclear Cardiac Studies, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT), Computerized Tomography Angiography (CTA), Magnetic Resonance Angiography (MRA), and Positron Emission Tomography (PET scan) are covered only if a Member or a Physician acting on a Member's behalf obtains Prior Authorization from HPI or its designee

- Virtual studies, such as virtual colonoscopy and capsule endoscopy studies.

LIMITED REFERRALS

A limited referral represents services/visits that have been reviewed and approved by the Plan Medical Director, for a specific time frame/number of visits. Visit limitations are determined based upon medical necessity and/or the member's benefit coverage.

A limited referral may be pended for up to fourteen (14) calendar days to ensure the necessary clinical documentation is received and reviewed by HealthPlus' Plan Medical Director(s).

Process for submission:

- Indicate the total number of visits you are requesting in the "Total # of Procedure/Visit" field on the Referral Request screen.
- Date ranges are required and can be limited to one day but no greater than 365 days. When additional services are needed, after the requested date range expires, a new referral must be submitted for ongoing care.
- Limited Referrals can only be issued by the member's primary care provider. Specialists are not allowed to refer to another specialist for additional services.
- Limited Referrals must be submitted at least 14 days prior to the member receiving the requested service(s). If less 14 days, please call the Referral department directly.

Excluded Services (include, but are not limited to):

- Services for County Health Plan enrollees
- Services for HealthPlus Options enrollees
- Services for HealthPlus Point of Service members
- Services to Tertiary Hospitals
- Podiatry services
- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic services
- Services rendered by non-contracted and/or out-of-plan specialty providers
- Services requiring review for medical necessity
- Pharmaceuticals
- Diabetic shoes and inserts

Surgeries/Procedures (include, but are not limited to):

- Bariatric/Weight management
- Dental services
- Orthognathic and TMJ treatments
- Frenectomy/frenulectomy/frenoplasty
- Patatopharyngoplasty/Uvulopalatopharyngoplasty
- Elective termination of pregnancy
- Organ and tissue transplants
- Autologous chondrocyte transplant
- Experimental/Investigational services
- Infertility services
- Dorsal column stimulators/spinal cord stimulators
- Ductal lavage
- External Counterpulsation
- Left ventricular assistive devices
- Uterine artery embolization
- Cosmetic procedures

Services Not Requiring a Referral or Prior Authorization

For certain specialty services provided within the HealthPlus network or by a contracted practitioner/provider, no referral is required from the PCP. Examples of services not requiring a referral include, but are not limited to:

- Well women visits
- Eye exams for diabetics
- Emergency services (see below)
- In-plan home health and hospice services**,** except for the UAW Retiree Medical Benefits Trust (RMBT) members and non-contracted PPO home health care and hospice services
- In-Plan specialty:
  - Critical Care Specialist
  - Gastroenterology
  - Gynecology/Oncology
  - Hematology/Oncology
  - Hospitalist
  - Maternal and Fetal Medicine
  - Nephrology
  - Neurology
  - Oncology
  - Optometry
  - Perinatology
  - Pulmonary Medicine
  - Radiation Oncology
  - Rheumatology

Urgent and Emergent Requests

HealthPlus does not review for authorization or deny emergency or urgent care services. Emergency services are covered in accordance with the member contract.
HealthPlus does not review for authorization nor deny emergency or urgent care services. Emergency services are covered in accordance with the member contract.

Urgent/emergent request are defined as:

- Any request that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based upon a prudent layperson's judgment, or;

- Made in the opinion of a practitioner, with knowledge that the member's medical condition would subject the member to severe pain that cannot be adequately

managed without the care or treatment of the requested service(s).

Contact Numbers for urgent requests: (800) 733-6360 or (800) 942-5974

REFERRAL VISUAL AIDS

To enter a new referral:

(1) Select the type of referral. Open or Limited.

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- Claims
- Referrals
  - Referral Inquiry
  - Submit Referrals:
    - OPEN REFERRAL
    - LIMITED REFERRAL
- Members
- Provider

Welcome

Provider Service Center
Welcome to the HealthPlus provider service center specifically designed for you, our valued provider. Click on the menu to the left to access member eligibility and benefit information, claim and referral inquiry, referral submission and more!

Access our Provider manual

For Open Referral, Limited Referral and Referral submission instructions: Click Here

Need some help? Click Here to open a copy of our entire service center user guide.

Message Center (Inbox)

From	Subject	Received

» Event Calendar

(2) Select the referring provider **(3) Insert member name details (DOB is optional)** **(4) Select search**

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  - Referral Inquiry
  - Submit Referrals:
    - OPEN REFERRAL
    - LIMITED REFERRAL
- Members
- Provider

Home

Panel Roster

This page enables you to view a list of members currently assigned to a provider as primary care physician (PCP). This list is updated nightly, and will not reflect changes made today.

Select a Provider

Provider Name

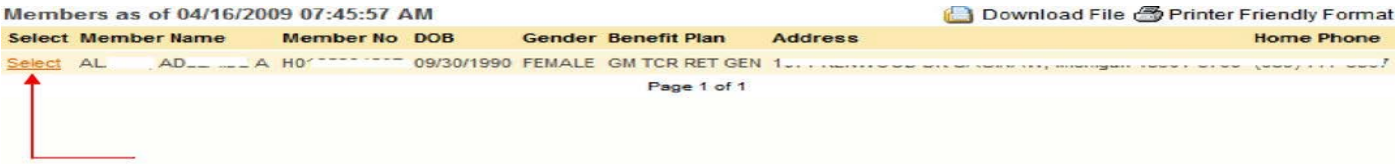
Member Last Name

First Name

DOB (mm/dd/yyyy)

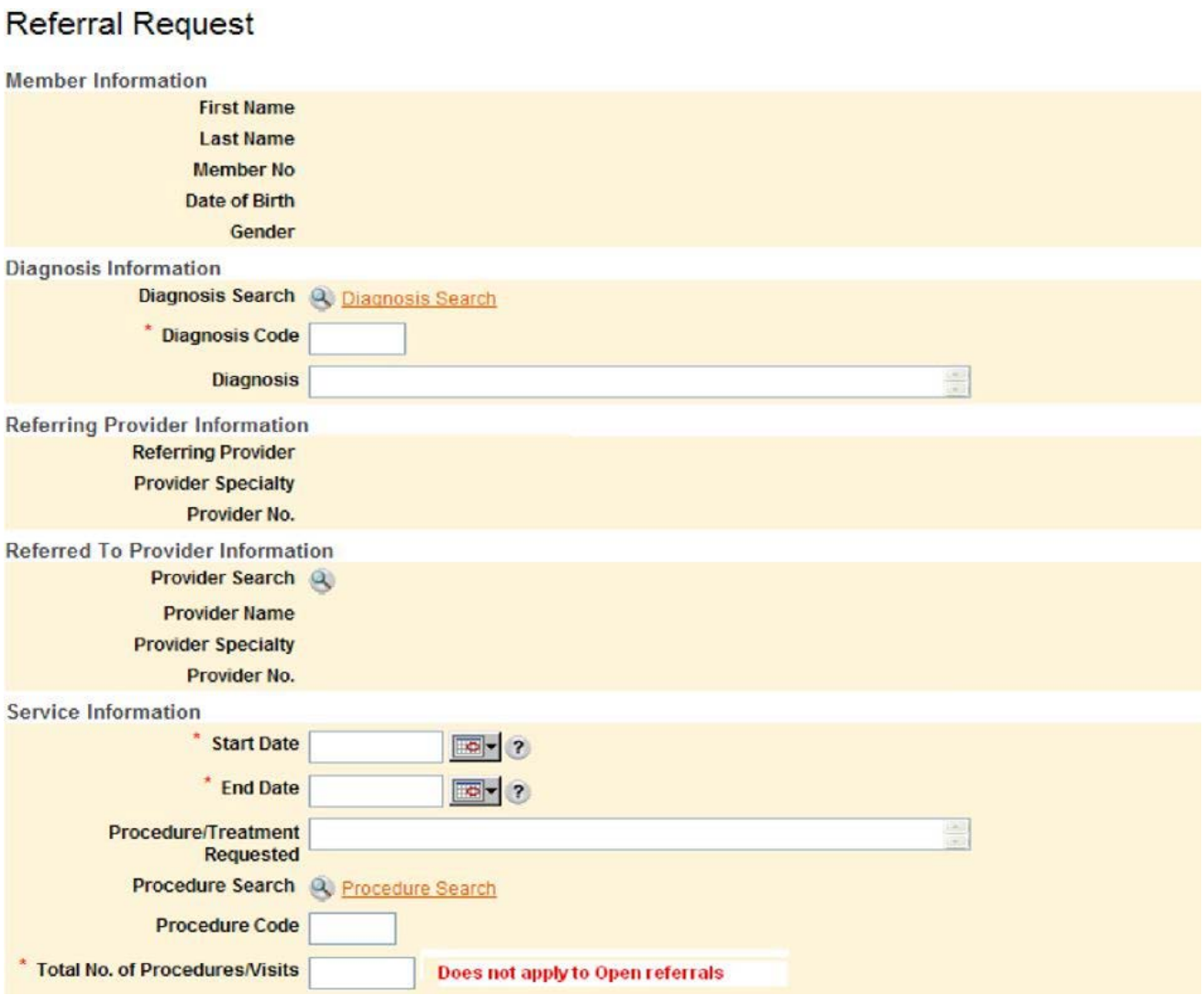
Search

(5) Click "select" next to the member



(6) Enter referral information

- Click the Magnifying glass next to "Diagnosis Search" to do a search for a diagnosis, or enter a valid diagnosis code. If the Diagnosis Code is more than 3 digits, a period (.) must be applied after the 3rd digit, Ex: 250.00. More detail may optionally be entered in the Diagnosis text box below the code.
- To select the referred to provider, click the magnifying glass next to 'Provider Search', search and select the provider. The information will be returned to this screen.
- Enter the start and end dates for the referral.
- Enter reason, procedure and/or location for referral in the 'Treatments/Testing to date field.
- For limited referrals only - enter the number of treatments/visits/days.
- Enter procedure code if necessary (not required).
- Review carefully, the information that you have entered. Once you click Submit, you cannot retract or change any of the referral submission fields.
- Click the Next button



(7) Review the referral information before submission.

Referral Request - Review and Submit

Member Information

First Name	
Last Name	
Member No	
Date of Birth	
Gender	

Diagnosis Information

Diagnosis Code	003.1 - SALMONELLA SEPTICEMIA
Diagnosis	

Referring Provider Information

Referring Provider	
Provider Specialty	
Provider No.	

Referred To Provider Information

Provider Name	
Provider Specialty	
Provider No.	

Service Information

Referral Status	Pended
Start Date	05/11/2010
End Date	05/11/2011
Procedure/Treatment Requested	
Procedure Code	
Total No. of Procedures/Visits	3

< Back Submit

The screen below displays after successful submission:

Home

REQUEST SUBMITTED

Thank you. Your referral has been submitted successfully!

Most in-network requests are processed and approved by the end of the next business day unless HealthPlus requires additional information to complete the referral. The status of this referral may be viewed online within two to three business days.

Printer Friendly Format

Referral Information

Printer Friendly Format

Printer Friendly Format

Referral Information

Pending Referral Number	I200016960
Referral Status	Pended

To confirm, check the status or modify a referral:

(1)Select the referral to be modified by selecting Referral Inquiry

(2) Select the referral you want to view or modify. Member name, contract numbers or pending referral number will return the best results.

- Claims
- Referrals
  - Referral Inquiry
- Members
- Provider

Home

Referral List

Enter information in one or more of the boxes below, and click 'Search' to return referrals.
Click the 'Detail' link in the referral results to access detailed information. Primary Care Providers - Click the Modify button to change dates and/or add visits to existing referrals.

Note: Only internet submitted referrals can be modified.

The receipt of an authorization for services through the Web site does not guarantee payment for such services. Any services that are indicated in the member's contract as "excluded" or "otherwise not covered services" will not be covered, regardless of whether he or she received a web-based authorization for such services.

Search — Printer Friendly Format

Member Information — Clear

Member Last Name
Member First Name
Member No

Provider Information — Clear

Provider Last Name
ProviderNo
Type: Servicing Provider / Requesting Provider

Authorization Information

Pending Referral No
Referral No
Referral Type Code
Referral Status
Submitted Online

Date Information

Search Date Type: Submission Date / Service Date
Time Frame
-OR-
Single Date (mm/dd/yyyy)
-OR-
Date Range to (mm/dd/yyyy)

Search

(3) Scroll to the bottom of the page select "detail" next to the referral you want to modify.

Results — Download File

	Pending Referral No	Referral No	Referral Status	Submission Date	Service Dates	Member No	Member Name	Requesting Provider Name	Referred To Provider Name
Detail									

(4) Confirm this is the correct referral and select "modify".

Home > Referral List

Referral Detail

Printer Friendly Format

Member Information

Member First Name	
Member Last Name	
Member Date of Birth	
Member Gender	
Member No	

Referring Provider

First Name	
Last Name	
Provider Specialty	
Provider No.	

Refer To Provider

First Name	
Last Name	
Provider Specialty	
Provider No	

Service Information

Referral No	
Referral Status	Certified in xxx
Service Date	00/00/2000
End Date	08/08/2009
Number of days/visits treatments	4
Procedure Code	

Done Modify

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(5) Change the dates for an Open and Limited referrals or add visits for Limited referrals only. Review and confirm the information before you submit.

Referral Detail

Member Information

Member First Name
Member Last Name
Member Date of Birth
Member Gender
Member No
Diagnosis

Referring Provider

First Name
Last Name
Provider Specialty
Provider No.

Refer To Provider

First Name
Last Name
Provider Specialty
Provider No

Service Information

Referral No
Referral Status Certified in total
* Service Date 08/18/2009
* End Date 08/18/2009
Treatments/Testing to Date

Treatments . Please enter the total numbers of treatments that the referral needs

Number of days/visits /treatments * 4
Procedure Code

*Required Fields

Submit Cancel