Referrals and Prior Authorization

A referral is a request by the primary care physician (PCP) to send a patient to a specialist for consultation, diagnostic intervention and/or treatment.

It is the responsibility of the PCP to submit the referral request within 24 hours of the patient visit. This ensures that care is not delayed while the member and specialist are informed of the referral status.

There are two types of referrals:

- In-Plan
- Out-of-Plan – requires medical necessity review and approval from HealthPlus

An in-plan referral is directed to a participating HealthPlus provider. PCPs are expected to refer to in-plan providers who use the hospital they are affiliated with whenever possible. When services are unavailable within the HealthPlus provider network, an out-of-plan referral may be requested and requires Medical Director review and approval.

Note: If your referrals are managed through a PHO, please follow the applicable procedures set forth in your agreement.

The PCP can initiate a referral in the following ways:

- *Through our website* at www.healthplus.org. This option for referral entry or inquiry is available 24 hours a day.
- *Via facsimile.* If you have been exempt from submitting via the Web, fax a completed copy of the HealthPlus referral form found on our website at www.healthplus.org in the *Provider* section to (810) 230-2086 or (989) 799-6471. Fax requests are not reviewed outside regular business hours.
- *Via telephone.* If you have been exempt from submitting via the Web, call the HealthPlus Referral Department between the hours of 9 a.m. and 4 p.m. at 1-800-733-6360 or 1-800-942-5974. If you are calling outside of the business hours listed above, call HealthPlus Customer Service at 1-800-332-9161.

Note: Urgent/emergent referral requests can be submitted 24 hours a day, but must be received by telephone.

HealthPlus will send referral notification to the patient, PCP and specialist. The notification will contain the referral number, approved dates and the scope of services to be rendered.

Note: If your referrals are managed through a PHO, please follow the applicable procedures set forth in your agreement.

For an in-plan referral, select a specialist from the HealthPlus Provider Directory. Whenever possible, select a specialist who uses the hospital you are affiliated with. Submit via our website, fax or phone (if you have been exempt from submitting via fax). The referral fax form is found on our website at www.healthplus.org in the *Provider* section.

The following information is needed to process a referral via phone or fax:

- Member's name
- Member's subscriber (contract) number, including relationship code (-01, -02, etc.)
- Provider to whom member is being referred and HealthPlus provider number
- Beginning and ending dates for the referral
- Number of visits and/or surgical procedure(s)
- Location where services will be performed. Efforts should be made to schedule all inpatient and outpatient services at the PCP's host hospital, outpatient surgery site or laboratory
- Diagnosis Code
- Diagnosis/reason for referral (clinical information)
- Related medical history of patient and procedural results relative to the current medical condition. Efforts should be made to communicate related testing and procedural information to specialists to reduce duplication of services

The specialist physician/provider should:

- Provide the authorized services
- Send a written report to the PCP
- Contact the PCP for approval and authorization of additional services

Note: If your referral process goes through a PHO, please follow the applicable procedures set forth in your agreement.

Due to the extensive amount of information necessary to process an out-of-plan referral, requests via the website require faxing of required information. As soon as you know an out-of-plan referral request is required, please telephone or fax the Referral Department with the information necessary to process an out-of-plan referral.

In addition to the information required for an in-plan referral, the following information is required to process an out-of-plan referral:

- Correct spelling of provider's first and last name
- Provider address
- Billing address, if different from physical address
- Provider telephone number
- Provider specialty
- Tax identification number
- DEA number
- NPI number

You will be instructed to submit supporting clinical documentation by fax to the Referral Department.

To avoid a denial because information does not support the request, submit all supporting documentation with the request.

If you have an urgent request because the medical status of a member is such that normal time frames (defined as 15 calendar days or 14 calendar days for Medicaid and Medicare Advantage) would seriously jeopardize the person's life or health or his or her ability to regain maximum function, call – do not submit via the website or fax. The decision-making time frame for an urgent request is 24 hours after receipt.

- Referrals are based on medical necessity
- The PCP must request all referrals to other HealthPlus participating providers
- Referrals can be updated or modified for a period of one year from the initial date, regardless of diagnosis. Example: One referral per specialist for any 12 month period
- Referrals must be complete in order to be processed. This includes the specialist's provider number(s), date spans, patient name and subscriber number
- A routine referral includes only outpatient services.
- Requests for services excluded from member's benefit coverage
- Neuropsychological testing is a medical service, therefore requires a referral from the PCP

The following procedures are not covered unless they are medically necessary. Services must be prior authorized by a HealthPlus Plan Medical Director and supporting documentation is required.

- Cosmetic surgery
- Treatment for varicose veins
- Mental health services
- Substance abuse services
- Infertility services
- Oral surgery and related services
- Organ and tissue transplants
- Ophthalmological services for diagnoses of pre-glaucoma, or pre-cataracts
- Weight management services
- Uvulopalatopharyngoplasty
- Ductal lavage
- External counterpulsation
- Autologous chondrocyte transplant
- Left ventricular assistive devices
- Uterine artery embolization

This list is not all-inclusive. For questions regarding services that need to be reviewed for coverage determination prior to services being rendered, please contact Customer Service at 1-800-332-9161.

- For Federal employees and Medicaid members, termination of pregnancy (TOP) is only a benefit in cases of rape, incest or if the mother's life is in danger.
- Members in all product lines may self-refer for behavioral health services. PCPs may also be consulted, but no referral is necessary. The behavioral health provider will call HealthPlus for authorization.

Michigan law requires all HMOs to permit female members to access an affiliated OB/GYN for "annual well-woman examinations and routine obstetrical (provided their benefit package has this benefit) and gynecological services" without prior authorization or referral. HealthPlus allows members to seek an annual exam from inplan providers without a referral; however, an authorization or referral is required for HealthPlus members who choose to see a non-affiliated (out-of-plan) OB/GYN for these services.

For female members who choose to self-refer for an annual well-woman exam, HealthPlus encourages these members to communicate with the PCP concerning the selection of an in-plan OB/GYN physician, choosing a provider from among the preferred group of specialists with whom her PCP is affiliated.

Annual Well-Woman Exam

A standard annual well-woman exam should include all of the components of preventive medicine examinations, including a comprehensive examination, counseling, anticipatory guidance and the ordering of appropriate laboratory diagnostic procedures (performed on the same day in your office).

CPT codes 99384-99387 and 99394-99397 should be used when billing HealthPlus. If the annual exam is performed by an OB/GYN and additional services are required, the OB/GYN provider must obtain a referral from the primary care physician.

Please note the following:

- A depo-provera injection or the insertion of Norplant can be provided during the annual well-woman exam. Please bill using the appropriate procedure code
- Medicare requires procedure code G0101 to be billed for a Pap, breast and pelvic exam. This code is acceptable for the supplemental Medicare claims submitted to HealthPlus for services
- Procedure code G0101 and Q0091 may also be billed for HealthPlus Commercial and Medicaid patients when only a Pap, breast and pelvic exam are performed
- If health concerns unrelated to the annual well-woman exam are diagnosed by the OB/GYN physician, the patient should be directed back to her PCP for care or a referral for services
- Q0091 can be billed in conjunction with a preventive exam code (i.e. 99384-99387 and 99394-99397) for Medicaid patients only

Routine Obstetrical Services

Routine obstetrical services (using standard CPT procedure codes) include the following:

- Prenatal visits
- Related lab work
- Related ultrasounds
- Amniocentesis
- Chorionic villi sampling
- Delivery, vaginal or cesarean
- Postpartum visit

Please note the following:

- A depo-provera injection or the insertion of Norplant can be provided at the postpartum visit. Please bill using the appropriate procedure code
- For routine obstetrical services, the primary hospital of the member's primary care physician should be used for the delivery, unless the hospital does not provide obstetrical services or an emergent or high risk situation exists
- If it becomes necessary during the course of the pregnancy to bill HealthPlus for three or less antepartum visits (i.e., patient miscarried, changed physicians, moved), please use the appropriate E/M CPT code. These visits will be covered without a referral
- If additional visits become necessary during the course of the pregnancy, or for illness such as colds, flu, etc... a referral is not required from the primary care physician. The appropriate E/M CPT code should be used with the primary diagnosis reports as diagnosis V22.0-V24.2 or 630-677. The secondary diagnosis should reflect the medical condition related to the specific patient visit
- Occasionally, a higher level procedure code needs to be billed, (i.e., for miscarriage, high-risk pregnancy). These visits do not require a referral, however, if a member needs to see a perinatologist, a referral is required from the primary care physician

Infertility Services

Infertility services do not require case management through HealthPlus. A referral is required providing the member meets certain criteria and has coverage for infertility services under his or her current contract.

The primary care physician's role is to:

- Determine the member's need for services
- Issue a referral for infertility services
- Maintain open communication with the infertility sub-specialist

Expected plans of care are important throughout the process for approval of subsequent tests and procedures. The infertility benefit is limited to a 12-month benefit period and begins with the first intrauterine insemination (IUI). Exclusions and their related costs will remain the same.

The member's responsibility will be to check their HealthPlus policy for coverage and any limitations to that coverage prior to seeking infertility services. A HealthPlus infertility evaluation form must be filled out and must accompany all referral requests.

There are two components to eye care:

- Routine vision services
- Medical services

HealthPlus Commercial

- Routine vision services are not usually a covered benefit. These services are usually covered under a vision insurance plan (i.e., Metropolitan, Vision Service Plan). For eligibility/benefit determination, please contact the HealthPlus Customer Service Department
- Medically-indicated eye care is covered under the member's HealthPlus medical benefit and a referral from the PCP is required

HealthPlus Partners (Medicaid)

No referral is required for the following covered benefits:

- A routine vision exam is a covered benefit every two years
- Glasses and frames are a covered benefit every two years
- Bill HealthPlus directly for services
- Bill HealthPlus for a medical condition performed by an optometrist
- All opthalmology services require a referral from the PCP and must be billed to HealthPlus
- To confirm member eligibility for routine vision services, specialists should go to www.healthplus.org and follow the prompts for member services.

HealthPlus MedicarePlus AdvantageHMO and AdvantagePPO

A routine vision exam is an annual covered benefit, if obtained through participating providers. No referral is required.

Note: If a medical condition is diagnosed during the routine exam, a referral from the PCP is required for the medically related services.

For members with a diagnosis of Diabetes, HealthPlus recommends a yearly retinal exam. No referral is required.

The member's primary care physician must complete a weight management data collection form found on our website at www.healthplus.org in the *Provider* section. The information requested on this form is required for the HealthPlus Medical Director to determine if the member meets the criteria outlined in the medical necessity guideline. If the information on the form is not complete and signed by the physician, the form will be sent back to the PCP's office for completion. A referral will not be entered until the form is completed and resubmitted.

If you have questions regarding the Weight Management form, please call the Referral Department at:

1-800-733-6360 or 1-800-942-5974

You may also call Customer Service at:

1-800-332-9161

The Pharmacy Department will process pharmacy requests for weight management pharmaceuticals. You may fax your requests to the following numbers:

(810) 720-2757 or (810) 797-4181

Pharmacy requests can also be called in to:

(810) 720-2757 or 1-877-710-0993

Prior Authorization Process for High-Tech Radiology Imaging

HealthPlus has partnered with CareCore National to manage our imaging management program for in-office and high-tech testing.

The goal of the program is to improve patient safety and quality of care through appropriate radiological testing and manage HealthPlus radiology costs and utilization compared to national benchmarks.

Program Specifics

- The program applies to Commercial/MIChild, Medicare Advantage, HealthPlus Partners (Medicaid), HealthPlus Options (self-funded TPA) HPI PPO, County Health Plans and where HealthPlus is secondary to other commercial insurance carriers. It is excluded for Medicare Supplemental.
- Prior authorization is required for outpatient, non-ER, high-tech testing, such as:
    - CT/CTA
    - MRI/MRA
    - PET
    - Nuclear medicine including PET
    - Nuclear cardiology

  Contact the HealthPlus Customer Service Department at 1-800-332-9161 for the most up to date summary of benefits for each line of business.

- Modality specific forms are available at www.healthplus.org in the *Provider* section and at www.carecorenational.com.
- Ordering physicians are responsible for obtaining prior authorization from CareCore
- The ordering physician and patient will receive notification of authorization or denial for test from CareCore
- One authorization number is assigned per CPT code request
- Authorization will be code specific with a pre-determined list of substitutions that will be allowed for select codes (e.g., CT with contrast, contagious body parts)
- Physicians do not need prior approval to order general x-rays or mammography

Physician Privileging to Perform General Low Tech Imaging in the Office

- PCPs and specialists may perform certain general low tech radiological tests in their office after submission and approval of equipment and technician documentation via the facility assessment form
- PCPs and specialists who wish to perform allowable general low tech radiology testing in the office must submit the HealthPlus/CareCore in-office assessment form to the HealthPlus Quality Assurance Department
- Offices will be notified of approval within 30 days of submission
- HealthPlus will continue to process all claims

Prior Authorization Process for High-Tech Radiological Imaging

- The physician determines if a test is needed

- A list of codes needing prior authorization may be obtained through www.healthplus.org. Go to the *Provider* section and then click on *the HealthPlus Imaging Management Program* link
- The physician's office should provide:

    - Clinical information (patient symptoms with duration)
    - Prior management or interventions (i.e. surgeries or physical therapy with results, any medications given with info on dose, duration and results)
    - Include any previous diagnostic imaging with results

To direct a request to CareCore

You can use the CareCore National website:

www.carecorenational.com

You may call:

1-800-792-8744

You can fax:

1-866-466-6964

- CareCore clinical staff will review the medical documentation submitted for every request:
    - Issues authorization, if appropriate
    - Issues redirection or denial
    - A CareCore physician is available for discussion of the case. Call CareCore's Physician to Physician phone line at 1-800-792-8744, ext. 11858
- CareCore sends confirmation to the ordering physician (via fax and mail) and member (via mail)
- Physician offices may check the CareCore National website for status of authorization requests at www.carecorenational.com (provider ID number, patient ID and date of birth required)
- After authorization is received, the member's services may be scheduled
- Physicians may appeal to CareCore on behalf of the member for denials
- Instructions for submitting requests for appeals will be provided to the physician in the denial letter

Note: Complete clinical information is the key to quick turnaround.

Appealing A Denial Decision

If a request is denied, the physician may submit written comments, documents or other information important to an appeal, directly to CareCore. All first requests are appealed directly to CareCore. Follow the appeal instructions given to you in the CareCore denial letter. In order to request an appeal, you can write, call, fax or hand deliver your request to:

CareCore National, LLC
Attn: Clinical Appeals, Mail Stop 600
169 Myers Corners Road
Wappingers Falls, NY 12590
Fax: 1-866-699-8128

Telephone: 1-800-792-8744

Please be advised that Medicare Advantage appeals are not handled through CareCore National. These are sent directly to the HealthPlus address below.

If CareCore is not able to approve an appeal, the physician may request a second appeal to HealthPlus. In order to request an appeal, write, call, fax or hand deliver your request to:

HealthPlus of Michigan/HealthPlus Insurance
Attn: Appeals/ Imaging Management Program
2050 S. Linden Road
Flint , MI 48532

Fax: (810) 230-2002
Telephone: (810) 496-8403

Freestanding Site Process

- The facility must complete a freestanding facility assessment tool. CareCore staff will review the documentation, conduct a site assessment review, review findings with HealthPlus and approve the site if criteria is met
- At patient registration, staff may verify the prior authorization number and obtain the codes being authorized by one of these options:
  - Visiting the CareCore website, www.carecorenational.com. (The provider ID, patient ID and date of birth are needed for verification)
  - Calling CareCore Customer Service at 1-800-792-8744
  - Requesting approval letter from the member
- If the exam is approved and the prior authorization number is verified, the patient may receive testing.
- The hospital bills HealthPlus for the test with the prior authorization number included on the claim
- If the exam is not approved or prior authorization has not been obtained, contact CareCore Customer Service to determine if the authorization is in process. If it is not in process, contact the ordering physician

Note: In certain STAT situations, the ordering physician may obtain authorization within two business days after the date of service. The service must have been provided on an urgent basis, outside of CareCore's business hours of 6 a.m. to 7 p.m.

Question	Answer	Additional Information
Do mental health services require a referral for Commercial members?	Members may access mental health/substance abuse services in one of three ways: ▪ Self-refer to a panel provider ▪ Call HealthPlus Behavioral Health Department for names and numbers of practitioners ▪ Consult with a PCP	HealthPlus Behavioral Health Department: 1-800- 555-5025
Are mental health/substance abuse services covered for HealthPlus Partners Medicaid members?	Outpatient mental health services are covered by HealthPlus Medicaid. No PCP referral is required. Substance abuse services are carved out for HealthPlus Partners. Members may access substance abuse services through the local Substance Abuse Coordinating Agency.	In Genesee, Lapeer and Shiawassee counties, members must call Hurley Mental Health Associates at: 1-800-742-1910 Members in all other counties may either self-refer to a panel provider or call the HealthPlus Behavioral Health Department at: 1-800-555-5025
Does routine vision care require a referral for HealthPlus Partners Medicaid members?	No referral is required. For eligibility/benefit determination, go to www.healthplus.org. If a medical diagnosis is made, the member's PCP must authorize further care.	HealthPlus Customer Service Department: 1-800-332-9161

Is a routine vision exam usually a covered benefit for HealthPlus Commercial members?	No, unless the member has a history of diabetes or is employed at a business that provides this coverage. If a medical diagnosis is made, the member's PCP must authorize further care.	HealthPlus Customer Service Department: 1-800-332-9161
Is a routine vision exam a covered benefit for HealthPlus Senior members, and does it require a referral?	Yes, a routine vision exam is a covered benefit annually when received from a participating provider. No referral is necessary from a participating provider. If a medical diagnosis is made, the member's PCP must authorize further care. For members with a diagnosis of diabetes, a yearly retinal exam is recommended. No referral is necessary.	HealthPlus Customer Service Department: 1-800-332-9161
Where do I send documentation for out-of-plan referrals?	Please fax this information to the HealthPlus Referral Department.	HealthPlus Referral Department: (810) 230-2086 or (989) 799-6471
How do I obtain a HealthPlus specialist provider number list?	Go to www.healthplus.org for the most up-to-date list or contact your provider service representative for assistance.	HealthPlus Provider Network Department: (810) 230-2267 or (989) 797-4009
How do I verify if a service is a covered benefit for referral purposes?	Go to www.healthplus.org or contact the HealthPlus Customer Service Department.	HealthPlus Customer Service Department: 1-800-332-9161
I'm a vision provider. If a HealthPlus member comes to me for a routine exam without a referral and I discover a medical condition, what do I do?	The member must be referred back to his or her PCP for care or a referral for care.	
I'm a specialist provider. The member's referral says "one office visit." Can I do a procedure if necessary?	Yes. "One office visit" on the referral allows you to perform the procedures and/or treatments necessary that day in your office.	

I'm a specialist provider. The member's referral says "consultation only." Can I perform a procedure during the visit?	No. "Consultation only" referrals indicate the PCP wishes to review a written report before authorizing further visits and/or procedures.	
I'm a specialist provider. The member's referral says services should be provided at the "PCP's hospital." Can I use a different hospital?	No. Inpatient and outpatient hospital services should always be provided at the PCP's affiliated hospital unless the service is not available at that facility. If you are not sure of the hospital affiliation, contact the PCP or HealthPlus Customer Service.	HealthPlus Customer Service Department: 1-800-332-9161
I'm an OB/GYN provider. If a HealthPlus member comes to me for her annual exam without a referral and I discover she has an unrelated diagnosis which needs to be treated (i.e., the flu, an infection), what do I do?	The annual well-woman exam is billed with a well diagnosis code. For unrelated services, please direct the patient back to her PCP for care or a referral for care.	
If a HealthPlus member wants a Depo-Provera injection or Norplant insertion during the well-woman exam or at the postpartum visit, can this be done?	Yes. Please bill the appropriate procedure code for the contraceptive provided. It is a covered benefit. Go to www.healthplus.org or contact HealthPlus Customer Service to verify coverage.	HealthPlus Customer Service Department: 1-800-332-9161
I'm a specialist provider. What if I wish to refer a HealthPlus member to another provider?	The PCP must initiate the referral. Contact the PCP or send the patient back to the PCP for follow-up.	