

**Administrative Simplification**  
**Operational Guidelines**

**Simplification Area:** Referrals

**Topic:** Referral Actions – Standard Terminology, Meaning, Implications and Form

**Objective:** Clarify and Standardize the different types of ‘Referral Actions’ and how health plans will reimburse services. Accept a standard form.

**Expected Impact:** *Patient* – The patient’s experience can be negatively impacted when the PCP’s expected referral action is not clear to the specialist. Scheduling of the service may be delayed and/or the patient may receive a bill.

*Medical Practices* – In those cases when services delivered by a specialist were not eligible for coverage, due to the type of referral action specified by the PCP, claims may be denied. Staff in the specialist’s office spends at least 1 hour per denied claim following up with the health plan and the PCP. Finding time to rework and resubmit the claim adds at least 10 days to the payment turnaround time.

Staff in the PCP’s office spends at least 15 minutes working with the specialist’s staff to reprocess the referral.

*Hospital* – When the PCP/Specialist are not clear about referral requirements, hospital admitting staff spends at least 40 minutes with them and the health plan sorting things out.

*Health Plans* – Staff spends at least 3 minutes, per call from a PCP or specialist, to research and explain why a claim was denied/underpaid because the service delivered was not eligible for coverage given the referral action.

Staff enters information from referral forms into the health plan’s system. At least 2 minutes could be saved, per form, if a standard referral form was used.

**Synopsis:**

*This guideline only applies when a health plan requires a referral.*

Standard terminology is recommended for referrals actions from one practitioner to another. When the standard terminology is used, health plans will reimburse services related to those referrals according to common and consistent practices.

When notifying health plans, a practitioner should identify the referral action as one of the following:

- Consult-Only
- Evaluate & Treat
- Evaluate & Treat – Surgery/Procedure if Indicated
- Itemized Services
- Assume Management

All participating health plans will accept the Standard CHITA Referral Form available at [www.wahealthcareforum.org/AdminSimp/Referral\\_Review/Docs/CHITA\\_form\\_03.pdf](http://www.wahealthcareforum.org/AdminSimp/Referral_Review/Docs/CHITA_form_03.pdf). This form has been updated to reflect the standard Referral Actions.

Participating health plans will accept other referral forms as well. Providers are encouraged to incorporate the above Referral Action on their forms.

**Background:**

When a practitioner (usually a PCP) refers a patient to another practitioner (usually a specialist), he/she typically sends along instructions about the type of care that the specialist should deliver. For patients with managed care health coverage, these instructions should also be sent to the respective health plan to indicate that the PCP has authorized the specialist to provide care.

Different practitioners use different terminology for referral instructions and sometimes use the same terminology to mean different things. Different health plans interpret the terminology to mean different things. These differences create confusion for practitioners and for health plans. Specialists are not always clear about what a PCP expects of them and are not always clear which services will be reimbursed by the health plans. Specialists must take extra time to get clarifications from PCPs and health plans, or run the risk of not being reimbursed for services at the highest level. At times, the process of getting clarification may delay the care that is delivered to a patient.

The number of different referral forms that are sent and received also add to the complexity of the referral process. Practitioners try to keep track of which form to send to which health plan. Health plans try to figure out where to find the information they need and to interpret what is intended.

## **Important Definitions:**

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.**

## **Operational Guidelines:**

Health plans and practitioners participating in the Administrative Simplification process have agreed to:

- Common terminology for specifying referral instructions, i.e., Referral Actions
- Standard guidelines for which care services will be eligible for reimbursement
- Accept the CHITA Standard Referral Form (available at [www.wahealthcareforum.org/AdminSimp/Referral\\_Review/Docs/CHITA\\_form\\_03.pdf](http://www.wahealthcareforum.org/AdminSimp/Referral_Review/Docs/CHITA_form_03.pdf))

The CHITA Standard Referral Form has been updated to reflect the Referral Action terminology. The Forum encourages other providers and health plans to adopt and use this terminology as part of the referral information. Participating health plans will accept other referral forms as well. Providers are encouraged to incorporate the above Referral Action on their forms.

If providers follow these standard guidelines and incorporate this common terminology into their referral practices, confusion and unexpected outcomes, pertaining to how health plans process referrals and subsequent claims, should be reduced.

What terminology should be used for Referral Actions?

When a patient is referred to a specialist, the following terminology is recommended to describe the action that is requested of the ‘referred to’ practitioner.

Referral Actions

- Consult-Only
- Evaluate & Treat
- Evaluate & Treat – Surgery/Procedure if Indicated
- Itemized Services (which must be itemized on the referral)
- Assume Management (limited to patient’s current, medical condition as specified on the referral)

If one of the above ‘Referral Actions’ is not specified in the referral information, the health plan will assume the referral action listed in the table below and will process the referral and the associated claim accordingly.

Health Plan	Consult-Only	Evaluate & Treat – Surgery/Procedure if Indicated
Community Health Plan of Washington	X	
First Choice Health	X	
Group Health Cooperative	X	
Molina Healthcare	X (no referral req. for par providers except oncology referrals.)	
Regence BlueShield		X

A case may arise where the PCP refers a patient to a surgeon and selects ‘Evaluate & Treat’ as the Referral Action. The surgeon, upon seeing the patient, may determine that surgery is required. For surgery related charges to be reimbursed by the health plan at the highest benefit level, the PCP should issue another referral and select ‘Evaluate & Treat – Surgery/Procedure if Indicated’ as the Referral Action.

What Services will be Reimbursed for each Referral Action?

Each ‘Referral Action’ will be associated with a set of care services that fall within its scope. The following is the recommended mapping of Referral Actions to Types of Services. The ‘X’ indicates the types of care services that are eligible for reimbursement for each Referral Action. For example, when the Referral Action is ‘Evaluate & Treat - Surgery/Procedure if indicated’, the services that are eligible for reimbursement include pre-surgery labs, xrays and other diagnostic testing.

## Mapping of Referral Actions to Reimbursable Services

- Patients must be eligible for referred services under their policy or claims for those services will be denied.

- In order for claims for referred services to be reimbursed at the highest level, Referral and Prospective Review requirements must be met. For some services, the referral itself is not sufficient. A preauthorization is also required which must be obtained by the “referred to” provider. See respective grids for referral and prospective review requirements that are specific to each health plan.

- Limitations may be imposed by the provider or the health plans related to the # of visits and/or timeframes for service delivery. As an example, for an ‘evaluate and treat’ referral, a health plan may have a limit of 3 visits within 90 days. The specialist should check with the health plan with any questions about limitations.

Types of Services Referral Actions	Office Visits	Diag. Testing	In-office Proc.	In/out facility Proc.	Itemized Service	Refer-on	Important Comments
Consult-Only	X						Molina: No referral required for participating specialist office visits.
Evaluate & Treat	X	X	X				Check with health plan for number or time limitations
Evaluate & Treat - Surgery/ Procedure if indicated	X	X	X	X			Check with health plan for number or time limitations  Molina: No referral required for in office procedures. In/Out facility procedures do require referral or prospective review based on code.
Itemized Services (must be itemized on the referral)					X		Use this referral action for Molina when services require prospective review
Assume Management (limited)	X	X	X	X	X	X	• Only Regence

Types of Services Referral Actions	Office Visits	Diag. Testing	In-office Proc.	In/out facility Proc.	Itemized Service	Refer-on	Important Comments
to patient's current, medical condition as specified on the referral)							BlueShield • Only to MD & DO

*Office Visit:* Visits to the ‘referred to’ practitioner, where physical examination and conversation take place, possibly reviewing tests the PCP may have sent with patient or which patient brought along. These services can only be performed by the ‘referred to’ practitioner.

*Diagnostic Testing:* Non-invasive services, e.g., laboratory tests, xrays, and diagnostic imaging. Does not include invasive procedures such as heart catheter. These services can be performed by the ‘referred to’ practitioner and/or by an ancillary service organization such as a reference laboratory, imaging center, etc. A referral to the ancillary services organization from the PCP or the ‘referred to’ practitioner is typically not required.

*In-office Procedure:* Procedures/surgeries that are performed in the offices of the ‘referred-to’ provider, e.g., colposcopy, mole removal, cast application/removal, biopsies, etc. These services can only be performed by the ‘referred to’ practitioner.

*Inpatient/Outpatient Facility Procedure:* Procedures/surgeries that are performed at a location other than the offices of the ‘referred-to’ provider. These locations may include an outpatient surgical suite or a hospital. These services can only performed by the ‘referred to’ practitioner.

Health plans have different policies for where a particular surgery/procedure can be performed. For example, most health plans will reimburse lesion removal only as an in-office procedure, i.e., professional charges will be reimbursed, facility fees will not be reimbursed. Providers should check with the health plans with specific questions.

*Itemized Services:* Any procedure/service that is specified. May include those listed above and/or other services such as Prosthetics, Home Health, Outpatient-Hospice, Home infusion, other procedure/surgery, etc. These services can be provided by the ‘referred-to’ practitioner or an ancillary service organization such as an imaging center, a health care agency or a DME vendor. **Please refer to Referral grid for more information.** (Review the appropriate Referral and/or Prospective Review Table, which can be found at the Forum’s

website at [www.wahealthcareforum.org](http://www.wahealthcareforum.org). The path is Admin Simp Policies & Guidelines / Referrals and Prospective Review.)

*Refer-On:*

*This only applies to Regence BlueShield and only when the Referral Action is 'Assume Management'. The PCP authorizes the 'referred to' practitioner to refer the patient to another MD or DO practitioner for more specialized treatment, if and as appropriate. This treatment must be related to the patient's medical condition as specified on the initial referral from the PCP. The 'referred-to' practitioner can send the patient to another practitioner for an in-office visit, but cannot instruct another practitioner to 'Assume Management'.*

General Scenario:

- 1.) PCP sends a patient to specialist A for Assume Management of a specified condition.
- 2.) Specialist A can refer the patient to specialist B, C, or D for an office visit or an in-office procedure related to the condition specified by the PCP. Specialist A cannot refer the patient for Assume Management.
- 3.) Specialist B, C, or D cannot refer the patient to any other provider.

Specific Example:

- 1.) PCP sends a patient to an osteopath to Assume Management for an identified condition.
- 2.) The osteopath CAN send the patient to a neurologist for an office visit or an in-office procedure, related to the condition.
- 3.) The neurologist CANNOT perform a procedure in any other location other than their office and CANNOT refer the patient to any other provider.
- 4.) The PCP can send the patient to an internist to Assume Management for another condition.

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

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 83 on the UB-92 or box 17 on the HCFA 1500.

**Referral Processing Considerations:**

Health plans assume that the PCP will allow the ‘referred to’ practitioner to deliver all services that fall within the scope of the ‘Referral Action’. **(Note - Group Health will adjudicate the referral and will identify the specific services they will authorize for payment.)**

It is possible that a PCP may refer a patient for a service that is not a covered service under the patient’s policy. Health plans will not reimburse the provider for non-covered services. A PCP may also refer a patient for a number of services that exceeds the patient’s benefit level. Health plans will process claims for eligible benefits on a “first-in, first paid basis” until the patient’s benefit levels are met.

Health plans will reimburse for services, at the highest level, when a contracted practitioner provides those services. If a patient is referred to a practitioner that is not a contracted provider, the patient will likely be responsible for paying some or all of the cost of those services.