I. SCOPE:

This document describes the Health Plan claims procedure for payment of non-participating providers for referral services.

II. POLICY:

In the event that Health Care Services required for treatment of a medical condition are not available through a participating provider, a Health Plan member may be referred to a non-participating provider in accordance with approved procedures for referral to non-participating providers.

Such a referral by a primary care physician will be authorized and entered on an authorization screen utilizing the following guidelines:

III. PROCEDURE:

A. When a referral to a non-participating provider is authorized in advance, medical health/services staff obtains a non-par ID number from the Corporate Provider Number Assignment Department for input in the specialty provider field of the authorization screen.

B. The referral authorization will cover only the designated level of service or modalities of services described on the authorization screen for the specific date, date range or with a grace period of 1 day prior to and 10 days after the date or date range indicated (where applicable).

C. Where services are rendered at a non-par hospital-based facility and a facility charge is applied, reimbursement of the facility charge is made at the Medicaid or Medicare rate of reimbursement.

D. Laboratory, radiology and pharmacy services (par or non-par) rendered in conjunction with an approved referral to a non-participating physician will be covered if specified in the comments section, or as a component of the outpatient or inpatient hospital authorization, if provided on the specific date within the specific date range of authorized services.

1. If there is no authorization present for the non-par laboratory, or no reference to the non-par laboratory in the authorization for the par-provider (when applicable), the non-par laboratory claim will be denied reason code 88 (non-par provider not authorized).