

<b>VIII. REFERRAL PROCEDURES</b>	
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**VIII. REFERRAL PROCEDURES**

PCPs are responsible for initiating and coordinating referrals of members for medically necessary services beyond the scope of their contract or practice. PCPs and Specialists are to monitor the progress of referred members' care. Specialists must see that members are returned to the PCP's care as soon as medically appropriate.

Missouri Care Network Providers are required to refer members to within network unless the necessary services are not available by a contracted Provider. In those cases, the referring Provider must request Prior Authorization (See Section IX, Prior Authorization (PA) for more information).

**8.1 TYPES OF REFERRALS**

**A. REFERRALS TO NETWORK SPECIALISTS:**

PCP/PCO may refer members to contracted specialists by submitting a Missouri Care Specialty Referral form. The Specialty Referral form will cover the specialist's evaluation only (See Attachment VIII.A).

Specialty Referral forms are required for the following:

- Otolaryngology (ENT) Services for members over 21 years old
- Pain Management Services
- Therapy (speech, physical and occupational) \*
- Cardiac rehabilitation therapy
- Plastic Surgery
- Allergy Services for members over the 21 years old

*\* Services no longer covered for adults over the age of 21 receiving a limited benefit package, excluding pregnant women.*

Procedures performed by the specialist will require prior authorization. The Specialist must check to see if a prior authorization is required before rendering services, procedures and/or diagnostic testing. If a prior authorization is required, the Specialist must contact Missouri Care to obtain an authorization. (See Section IX, Prior Authorization (PA) for more information

PCP/PCO may refer a member to the following participating Specialists for consultation without a referral form or prior authorization:

Allergist -if member under 21	Nephrologist
Cardiologist	Neurologist
Dermatologist	Oncologist
Endocrinologist	Oncologist/Hematologist
ENT (Otolaryngologist) (if under 21)	Ophthalmologist
Gastroenterologist	Orthopedist
General Surgeon	Pediatrician
Gynecologist	Podiatry
Gynecology Oncologist	Pulmonologist
Infectious Disease	Radiation Oncologist
Neonatologist	Rheumatologist
Neurosurgeon	Urologist

**B. REFERRALS TO NETWORK PRIMARY CARE OBSTETRICIANS:**

A PCP may refer a pregnant member to a PCO (unless the PCP is also an obstetrical provider) immediately after the pregnancy is confirmed by submitting a Missouri Care Specialty Referral form to Missouri Care.

A PCP who is also an obstetrical provider (a physician, certified nurse midwife or nurse practitioner licensed to practice in the field of obstetrics /gynecology) may assume primary responsibility for supervising, coordinating and providing initial and primary care to pregnant member(s). In this case the PCP **must submit, either by mail or faxing, a Missouri Care Pregnancy Notification and Risk Screening form within two days of initial visit** (See attachment VIII B). Once the Pregnancy Notification and Risk Screening form is received by Missouri Care, an authorization number is issued and faxed back to the PCP. The Pregnancy Notification and Risk Screening form serves as an authorization for global OB services and is required for reimbursement.

A member may also self-refer to a contracted PCO. In this instance, the PCO must notify the Missouri Care Prior Authorization Department, either by mailing or faxing a Missouri Care Pregnancy Notification and Risk Screening form.

PCOs are to schedule an initial appointment with pregnant members within the applicable time frame after the request for the appointment:

- First trimester: within seven (7) business days
- Second trimester: within seven (7) business days
- Third trimester: within three (3) business days

High-risk conditions must be seen within three (3) business days of identification or immediately, if an emergency exists.

### C. EMERGENCY SERVICES

Emergencies do not require Specialty Referral forms or Prior Authorization. A health professional will perform; if possible, emergency services needed or immediately refer the member to the nearest and most appropriate facility without regard to prior authorization.

If a member receiving emergency services requires inpatient care, the facility is to contact the Prior Authorization Department within 24 hours of the admission to request authorization (in the case of the care occurring over the weekend, the next business day is appropriate).

### D. REFERRALS TO OUT OF NETWORK PROVIDERS

Referrals may be made to a nonparticipating health professional **ONLY** if the member requires medical services that are not available through an in-network provider. **Out of network Providers always require prior authorization and approval by the Missouri Care Medical Director.** The performing provider may be liable for any expenses resulting from services rendered without appropriate prior authorization and/or without medical necessity.

### E. ANCILLARY REFERRALS

Contracted Providers may make referrals to ancillary service Providers as follows:

#### Laboratory Referrals

The PCP/PCO may perform those lab tests for which he/she is CLIA-certified in the office or refer enrolled members to a contracted laboratory for Medically Necessary testing. **Out of network lab tests require PA.** PA is not required for in-network labs.

#### Infusion/Enteral Therapy

PCPs/PCOs may refer directly to contracted Providers. The contracted Provider is responsible for obtaining prior authorization before rendering service. For hospitalized members, the attending physician is to write an order for the service on the member's chart. All infusion external therapy require PA.

#### Durable Medical Equipment

Referrals for durable medical equipment (DME) are to be forwarded directly to the DME Provider. The DME Provider is responsible for obtaining PA. Member must be referred to a participating Provider.

#### Radiology

The PCP/PCO may perform contracted radiology procedures in the office or refer members to contracted radiology Providers or contracted

hospitals. Some Radiology services will require PA. The services listed in Chapter IX, section 4 do not require prior authorization; services not specifically listed require prior authorization.

## F. MEMBER SELF-REFERRALS

### Well Woman Examinations

Members may self-refer to any Provider one (1) time per year for a well woman examination, which includes a pap smear and any follow-up for abnormal findings.

### Mammograms

Members may self-refer to any contracted Provider for a mammogram, one (1) time per year.

### Emergency Room

Members may self-refer to the emergency room in an emergency situation. The emergency facility shall notify the PCP by next business day.

### Dental

Dental services for children under the age 21 include dental screens, routine dental services (dental examinations, fillings for cavities, or dental cleaning) and orthodontic services. It is recommended that preventive dental services and oral treatment for children begin at age 6-12 months and be repeated every six months or as medically indicated. Members may access dental providers directly or be referred by the PCP/PCO for routine services. Orthodontic services require prior authorization.

Dental services of pregnant women age 21 and over shall be limited to dentures and services related to trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. Services to prepare the mouth for dentures, such as examinations, X-rays, or extractions are covered through the Fee for Service Program.

Dental care for adults age 21 and over is limited to treatment related to trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. Dental treatment of a disease/medical condition without which the health of the recipient would be adversely affected is covered through the Fee for Service Program.

### Vision

Optical services for children under the age of 21 and pregnant women include but are not limited to eye exams, office visits, treatment, prosthetic eyes, eyeglasses, and EPSDT/HCY optical screens and services. Pregnant women age 21 and over do not receive eyeglasses except for one pair following cataract surgery. Eyeglasses for these pregnant women are covered through the Fee for Service Program.

Optical services for adults age 21 and over (except for pregnant women) are limited to a biennial eye examination only.

### Behavioral Health

Members can easily access service promptly without first going through a Primary Care Provider. These access methods include:

- Twenty-four (24)-hour telephone access to licensed clinicians via the toll-free DIRECT LINE (800) 889-4073 for assessment and necessary triage;
- Direct access to behavioral health network Providers for up to four (4) outpatient visits without prior authorization; and
- Immediate emergency care

### Family Planning

Missouri Care must allow members the freedom of choice and methods of accessing family planning services without requiring a referral from the PCP. Missouri Care shall reimburse clinics and Providers, including those funded by Title X of the Public Health Service Act, for all family planning services regardless of whether they are a participating or non-participating Provider. Unless otherwise negotiated, Missouri Care shall reimburse Providers of family planning services at the Medicaid Fee For Service rate.

Non-participating Providers are responsible for keeping family planning information confidential in favor of the individual member even if the member is a minor. Missouri Care is not responsible for the confidentiality of medical records maintained by non-participating Providers.

Family planning services include the following:

- Information and counseling on sexually transmitted diseases (STDs), contraception, screening for STDs, contraception management (including, but not limited to oral and injected contraception, Norplant, IUDs), and sterilization;
- Routine breast and pelvic exams and Papanicolaou (PAP) tests

If a member requires Medically Necessary services that are outside the scope of the PCP's practice, the PCP will refer the member to an appropriate network health professional. PCPs will monitor the care of referred member's care to ensure that the member is returned to the PCP's care as soon as possible.

To the extent required, a member will be permitted to self-refer out-of-network for family planning services, regardless of the availability of Providers within Missouri Care's network. Missouri Care will inform each member of his/her right to self-refer for family planning services, and other covered out-of-plan services. The right to self-refer will be discussed in printed materials related to these specific services in the Missouri Care member Handbook, and periodically through member newsletters or other mailings. The names of contracted self-referral Providers will be included in the Provider Directory. If the member informs the PCP that she has received services outside the network, the PCP should notify Missouri Care's Medical/Quality Management Department.

#### Public Health Agencies

There are a number of services, which members may access without a PCP referral that are provided by local public health agencies (LPHA). These may vary by each LPHA and shall include but not be limited to:

- Tuberculosis services
- HIV services
- Sexually transmitted disease services
- Immunizations
- Pregnancy tests
- WIC services
- Childhood lead poisoning screening, prevention & case management services
- EPSDT/HCY services (if rendered by a credentialed Provider)

Providers are required to coordinate with the LPHAs to ensure a member's continuity of care.

#### G. REFERRAL PROCESS

- The PCP is to complete, date, and sign (signature stamp is acceptable) the Missouri Care SPECIALTY REFERRAL form (see Attachment VIII. A).
- Forward designated copies as instructed on the SPECIALTY REFERRAL form, either by fax or mail; one (1) copy should be sent to Missouri Care, one (1) copy to the specialist Provider, and one (1) copy remains in the member's chart.
- Referring Provider must include pertinent clinical information with the referral.

#### H. PERIOD OF AUTHORIZATION

Members must be enrolled in Missouri Care on each date of service. Missouri Care Specialty Referral forms are valid for six (6) months and a maximum of three (3) visits beginning with the date the referral is dated and signed by the referring physician.

## I. BILLING/REIMBURSEMENT<sup>1</sup>

### 1. Billing

Claims will be considered for reimbursement only if they are appropriately authorized by Missouri Care and are a covered benefit for the enrolled member. If a Specialty Referral form or Prior Authorization was required, the Specialty Referral form number or Prior Authorization number must be entered on the appropriate billing form.

Exception: Contracted health professionals do not need to include referrals with radiology and laboratory claims.

### 2. Reimbursement

A referral does not guarantee reimbursement. Reimbursement depends on the member's enrollment on the date(s) of service, medical necessity, and Missouri Care limitations and exclusions as stated in rules and regulations of the MC+ program and the policies and procedures of Missouri Care.

## 8.2 BILLING MEMBERS

It is against the law for a provider to bill a Medicaid beneficiary for services included in their benefit package. In accordance with Title 13 CSR 70-030, when an enrolled Medicaid provider provides an item or service to a Medicaid recipient eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the recipient's Medicaid benefits and seeks reimbursement from the Medicaid agency in accordance with all the applicable Medicaid rules. The only exception to this rule is if the member failed to present their Medicaid ID card.

## 8.3 PRIVATE PAY AGREEMENT

In the case of any disputes regarding payment for covered services between the health plan and providers, the member shall not be charged for any of the disputed costs. This agreement shall only be overcome by written evidence of an agreement between the provider and the member indicating the member accepts the status and liabilities of a private pay patient. The private pay agreement shall only be for services not included in the comprehensive benefit package.

If you have questions regarding billing or the benefits covered by Missouri Care, please contact the Missouri Care Provider Relations Unit at 1-800-322-6027.

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<sup>1</sup> Refer to Section XI, Billing Procedures