

HEALTH ACTION

Referrals and Approvals for Medical Services

Understanding what to do when you think you need a referral to a specialist or authorization for treatment can be confusing. It is important to understand how your health plan works in order to take charge of your health care.



Follow your health plan's procedures for referrals and authorizations. The referral usually requires written confirmation or authorization.

BEGIN AT THE BEGINNING... PRIMARY CARE

Whether your health plan calls your doctor a Primary Care Physician (PCP) or you call him or her your family doctor, medical services begin here. Unless you become seriously ill or have a chronic condition that requires special treatment, this doctor usually can take care of most of your regular medical needs. It is important to build a good working relationship with your doctor based on honesty and trust.



If for some reason you would like to choose a different doctor, ask your health plan's customer service department how to go about finding a new one. You should be able to find the phone number in your "Evidence of Coverage" (EOC) or "Summary Plan Description" (SPD) that you got when you signed up with your plan.

The Health Maintenance Organization (HMO)

In this system - regardless of whether your coverage is purchased by you or your employer or provided through Medicare or Medi-Cal - medical services generally should be received from doctors and hospitals who contract with the health plan. In an HMO, your doctor probably will refer you to a specialist or admit you to a hospital that is contracted with the health plan. These are called "in-network" providers.



Plan ahead if you can. You may need to allow time for the referral or authorization process to take place. Leaving your medical problems that need treatment until the last minute may make it harder for your doctor to match your needs to the most appropriate specialist.

Referrals to specialists.

Because your doctor knows you and your health status, he or she often is in the best position to determine when you need to see another doctor or group of doctors for specialty treatment or tests. Regardless of your health plan type, this is called a referral. Some health plans require you to get a referral from your doctor before you can see someone else.

Only the health plan can approve your getting care from a doctor or hospital that does not have a contract with that health plan. Non-contracted doctors or hospitals are usually called "non-participating" or "out-of-network" providers. The only exceptions to this rule are made by the health plan:

- for emergencies (see page 3);
- when an appropriate doctor cannot be located within the network; or
- if you are in a plan that pays for out-of-network care.

In general, referrals are good for a certain number of visits and for a limited time period. Your doctor may have to ask for additional services or visits that are determined to be “medically necessary.” Prescription drug renewals usually must be approved by your doctor.



Plan ahead for prescription renewals. Your doctor may want to see you before renewing your prescription. If you wait until the medication is nearly gone, you may run out before your doctor can renew your prescription.

If you need follow-up care from a specialist after an emergency, contact your doctor or health plan in order to receive authorization for treatment. Even if the hospital where you were treated or admitted asks you to return, you should talk to your personal doctor before doing so. If you do not get the required referrals from your health plan you may have to pay the bill for your follow-up care. This can be expensive.

Understanding medical groups.

In some cases, your doctor will refer you only to a specialist who is in the same medical group as the doctor. If you want to see a specialist who is in a different medical group, but is still part of your health plan (an “in-network” provider), ask your doctor or your health plan for the procedures you need to follow.



Make sure the specialist's office has received your referral before you go. Call the specialist's office to confirm the time and date of your appointment and that the appropriate referral has been received. You may need to take the written referral with you to the specialist.

The exception to the rule in HMOs.

In some HMO plans, some services do not require your doctor's referral or prior approval. Check your health plan documents (EOC or SPD) or call your health plan's customer service department for any exceptions to the referral rule.



Confirm that you will be covered if you see a specialist without a referral from your doctor. Check with your health plan to be sure that the specialist is “in-network” or in the right medical group before you make an appointment.

The Preferred Provider Organization (PPO)

This system has some HMO-like features - such as a panel of contracted doctors you are encouraged to use who are “participating.” PPOs usually offer members the ability to use services outside the health plan's list (“out-of-network” or “non-participating” providers).



Check your contract to confirm your coverage. If you go outside of the network for care, you probably will be expected to pay a greater portion of the bill. You may have to pay a higher deductible as well as a larger coinsurance amount for the services you get from out-of-network providers.

In a PPO, you usually can make an appointment with a participating specialist without a referral. However, some services may require pre-approval or authorization. Examples are hospital admissions, some outpatient services such as physical therapy, medical equipment used in the home, or mental health care.

In addition, PPOs may limit the number of visits that will be covered by the health plan in any calendar year for some services such as physical therapy or mental health care. Check your EOC or SPD for any benefit limitations.

The Point-of-Service Plan (POS)

This type of coverage allows you to be in an HMO plan but choose to get care from doctors who are not in the HMO. This freedom of choice, however, requires that you pay a deductible and coinsurance up to a yearly maximum amount (sometimes called the “out-of-pocket maximum”) to see doctors who are not in the HMO.



Check your EOC or SPD to understand what your financial responsibilities will be for using non-HMO doctors. If the information is not clear, ask your health plan, insurance agent, employer, or union to explain it to you.

If you have POS coverage be sure you understand the procedures before getting services. Most people with Point-of-Service coverage get the majority of their care within the HMO and do not have additional out-of-pocket payments.

For both Preferred Provider Organizations (PPOs) and Point of Service (POS) plans, referrals to specialists are suggestions by your family doctor to see someone he or she thinks would be appropriate for your condition. There probably will be no paperwork involved in order for you to go to a specialist. Keep in mind, however, that going to a “non-participating” specialist may cost you more than going to a “participating,” or “in-network,” specialist.



Confirm the rules that apply to any doctor or service you use. Call the doctor's office to find out:

- *whether or not the doctor you have selected for specialized treatment or care is in your health plan;*
- *whether the doctor will bill you or the health plan for charges other than any copayment or deductible you might owe.*

Emergency Care

Regardless of your plan type, your health plan will want to be notified as soon as possible (generally within 24 to 48 hours) if you receive out-of-network emergency care or if you are admitted to a hospital for emergency services. Call a customer service representative and tell them why you needed the care, where you received it and what treatments or services were provided. A health plan representative probably will arrange for follow-up care in another facility or at your home if the hospital where you received emergency care does not participate in your health plan. All plans must cover emergency care, but you need to follow the plan rules and procedures to avoid problems later on.

WHAT TO DO IF YOUR REFERRAL IS DELAYED OR DENIED

Understand who has delayed or denied the referral. In some cases your doctor can't make the referral alone. He or she may have to receive permission from a medical group or health plan to make a referral. Your health plan's customer service department should be able to tell you who has the final say and who has the authority to deny or approve your or your doctor's request.



Follow-up with your doctor, medical group, or health plan if you disagree with a decision. You have the right to appeal any denial of service or benefits. You can file a complaint or grievance and ask for a different decision.

If you believe you have an immediate need for medical services that have been delayed by the referral process, talk to your doctor or contact your health plan's or medical group's customer service department for assistance right away.

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You have the right to a fast decision on your appeal if waiting 30 days would pose a serious threat to your health, such as loss of life, limb or major bodily function. Ask for an "expedited" appeal and explain why you need a quick decision. The plan must respond within three days.

For more information, see the Health Rights Hotline Action Guide "What To Do If You Have a Problem With Your Health Plan."

OUT-OF-NETWORK CARE AND THE COST TO YOU

If you choose to go to a hospital or see a doctor that is not part of your health plan, you will have to pay some, if not all, of the cost. What gets paid for and how much gets paid depends on the type of plan you are in and the reasons why you went to a hospital or doctor that is not in your health plan.

In an HMO, the only services that are covered by the HMO are those that you receive from a doctor or hospital that contracts with the HMO. If you go to a hospital or doctor outside of the HMO, you will have to pay the full cost of the services you receive unless you received prior authorization from the health plan. In general, an HMO will pay for services outside the plan only if the plan determines

that the services are medically necessary and are not available to you within the plan. For the HMO to pay for out-of-network services, you must have authorization from the plan before you receive the services.

In a PPO, you may be able to get some portion of out-of-network services paid for. In general, you will have to pay a higher portion of the cost than if you had received the services from a hospital or doctor that is part of the PPO network. Most PPOs do not require you to have authorization to go to a doctor outside the plan.

When in doubt, ask.

Finding out about your health plan's rules on referrals and authorizations can save you time and, in some cases, a great deal of money. It is your right and your responsibility to play an active role in your health care.

CALL THE HEALTH RIGHTS HOTLINE

Health care coverage can be complicated, but you do have rights. The HEALTH RIGHTS HOTLINE is here to assist you. The HEALTH RIGHTS HOTLINE is a totally independent, free service that provides information and assistance about your rights as a health care consumer. Experienced counselors will answer your questions and help you resolve issues with your medical group or health plan. If you need assistance, give us a call.



HEALTH RIGHTS HOTLINE

INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

519 - 12TH STREET, SACRAMENTO, CA 95814

SACRAMENTO: (916) 551-2100 • TOLL FREE: (888) 354-4474 • TDD: (916) 551-2180 • FAX: (916) 551-2158

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