Referrals

SoonerCare referrals:

- are made on the basis of medical necessity as determined by the PCP/CM

- are required for all inpatient hospital services except OB delivery

- are required prior to receiving the referred service. Referrals for inpatient admissions from an emergency room may be obtained in a reasonable period following the admission.

- must have the correct provider referral number to insure payment to the “referred to” provider (provider/referral numbers are site specific)

Referrals must be signed by the PCP/CM or a designee within the PCP/CM’s office who is authorized to sign for the provider.

Some services may also require prior authorization. It is up to the “referred to” provider, or provider ordering services, to obtain prior authorization as needed. Prior authorizations for services are obtained through the Medical Authorization Unit at OHCA.

SoonerCare referrals must be made:

- if the member requests a second opinion, further treatment related to the second opinion must be authorized through a referral made by the PCP/CM.
**SoonerCare** referrals may:
- be made to another PCP/CM for services equal to those of a specialist

Examples:
- A PCP/CM Family Practitioner who performs a surgical procedure
- A PCP/CM Internist who manages complicated diabetic members

**SoonerCare** referrals may:
- be made to a provider for ongoing treatment for a period of time specified by the PCP/CM, but limited to 12 months. For the duration of the referral, the “referred to” provider will not be required to receive further referrals to provide treatment for the specific illness indicated on the referral.

**SoonerCare** referrals are not required for:
- child physical / sexual abuse exams
- services provided by a PCP/CM for members enrolled or assigned to the PCP/CM
- emergency room visits
- obstetrical care
- vision screenings for members under 21
- basic dental for members under 21.
- behavioral / mental health
- family planning for members under 18
- services provided to Native Americans in a tribal, IHS, or Urban Indian Clinic facility

**Inappropriate Referrals**

Referrals should not be written for capitated services that are within the provider’s field of expertise or scope of practice. Federal regulations prohibit OHCA from paying twice for the same service.
Payment of Referred Services

- Payment for referred services is subject to coverage limitations under the current Medicaid reimbursement policies.

- Payment for referred services is limited to two (4) specialty visits per month for adults over age 21 whether self-referred or PCP/CM-referred. OB visits are excluded from this limitation.

- PCP/CMs must refer only to Medicaid providers who have an active Medicaid FFS contract to insure payment.

Documenting the Medical File

- Documentation in the medical record should include a copy of each referral to another health care provider and any additional referrals made by the “referred to” provider when this information is known, e.g. ancillary services.

- Documentation in the medical record should include a medical report from the provider to whom the referral was made. The “referred to” provider should report his findings to the referring PCP/CM within two weeks after the member’s appointment. In the event a medical report is not received within a reasonable amount of time the PCP/CM should contact the health care provider to whom the referral was made.

Unauthorized Use of a Provider’s Number

Unauthorized use of a SoonerCare provider’s number may result in official action to recover unauthorized reimbursements from the billing provider.
Referral Form and Instructions

In the *SoonerCare* program, the PCP/CM is responsible for providing primary care and making specialty referrals.

- The PCP/CM completes the referral form including the referral number. The PCP/CM’s *SoonerCare* provider number serves as their referral number. The provider/referral number is site specific and must be for the site at which the member is enrolled or assigned.

- The referral includes ancillary services rendered, or required, by the “referred to” specialist.

With the PCP/CM’s approval, a specialist may relay a copy of the original referral to other specialists with instructions considered necessary for proper treatment of the member. Payment is subject to the current Medicaid reimbursement policies.

Upon completion the form is distributed as follows:

1. The provider mails the original of the form to the specialist, or “referred to” provider.

2. A copy of the form is retained in the patient’s medical record.

When a claim is submitted by a “referred to” provider, the referral number must be entered in box 17a of the HCFA 1500 claim form, or box 83b of the UB92 hospital claim form. A copy of referral is NOT attached to the claim. If the referral number is not on the claim form, payment will be denied unless for self-referred services.

Providers with multiple sites must use the referral number for the site at which the member is assigned.
Referral forms can be accessed and printed from the OHCA website. www.ohca.state.ok.us.

If you are unable to access the Internet, referral forms may be obtained by calling the EDS Supply Line.