

PCP Referral/Authorization

Referral Information

Referrals are required for managed care services not provided by a beneficiary's PCP. Implied or "in-house" referrals do not require formal documentation. These are for services provided by a DCP. Referrals to other providers require documentation. OMS makes available a standard referral card that providers may use to verify referrals. Other examples of acceptable referrals include referral letters, hospital admittance letters, Certificates of Medical Necessity (CMN), and verbal/telephone authorizations. All referrals to providers other than DCPs must include:

- PCP name and provider number;
- Beneficiary name;
- Referred-to provider;
- Date of referral;
- Date span or number of visits; and
- Services or condition.

Verbal/telephone authorizations must also include the name of the individual conferring the referral/authorization.

Further Referral

When medically necessary, a referred-to provider may refer the recipient for further managed care covered services. A further referral/authorization can only be extended within the original time frame initially authorized by the recipient's PCP (not to exceed one year) and within the original service or condition authorized.

Retroactive Referral/Authorization

A referral/authorization is required prior to managed care services being performed. Managed care services that are not prior-authorized or prior-directed by the PCP or DCP are considered non-covered services.