REFERRALS

OVERVIEW

Referrals are a key component of continuity of care for South Dakota Medicaid recipients. Most medical services require either an attending, ordering, referring, or prescribing (ORP) provider for claims payment. For more information, view the provider enrollment chart.

Other program requirements such as medical necessity, eligibility, program prior authorization requirements, and coverage limitations apply even if a referral has been provided. Out of state services require both a referral and a prior authorization in most instances. For more information on prior authorizations refer to the Prior Authorization Manual.

ATTENDING, ORDERING, REFERRING OR PRESCRIBING PROVIDER (ORP)

In most situations the provider rendering the service as well as the provider billing for the service must have completed an online enrollment application and complied with the terms of participation as identified in the provider agreement and other applicable regulations including Administrative Rules of South Dakota ARSD § 67:16 which govern the Medicaid Program.

In the situation where the attending, ordering, referring, or prescribing (ORP) provider is not seeking direct reimbursement for their services (ex: hospital charges), South Dakota Medicaid has a streamlined enrollment process that generally requires no action on the part of the provider outside of claim submission for the ORP provider to be deemed “enrolled” for purposes of reimbursement.

Covered services being rendered by an individual who is ineligible to enroll (ex: CNA, RN), are generally addressed on the claim through the required listing of the eligible supervising or ORP physician, or supervising Qualified Mental Health Practitioner (QMHP) in the case of services at a Community Mental Health Center (CMHC) as noted in the Community Mental Health Centers manual. Services by an individual ineligible to enroll are subject to the rules, regulations and requirements of the South Dakota Medicaid Program. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

REQUIRED REFERRAL INFORMATION

The following information is required to complete a referral:

- Recipient name;
- Referred to provider’s name;
- Services or condition;
- Time-span (not to exceed one year);
- Provider name;
- NPI; and
- Date and authorized signature.

Providers may utilize the following methods of referral:

- Documented telephone referrals;
- Referral letters;
- Customized referral forms;
- Other insurance referral forms;
- Hospital admittance letters;
- Certificates of medical necessity (CMN);
- Referral cards;
- Other (must contain "required referral information").

In addition to required information, the provider may include other information such as:

- Specific directions;
- Progress notes;
- What services should be referred back to the provider.

REFERRAL RECORDS REQUIREMENTS

The referring and referred to provider must maintain documentation of the referral; documentation may be electronic or in writing. Following the provision of the specified services for the recipient, the referred to provider should transmit, electronically or in writing, the medical information, test results, and any diagnostic findings and treatment recommendations resulting from the provision of the service to the referring provider. In any such transmission, the referred to provider should specifically identify needs for additional care and treatment, including follow-up care. Upon receiving this transmission, the referring provider should incorporate the information transmitted into the patient's medical record.

CARE MANAGEMENT PROGRAMS

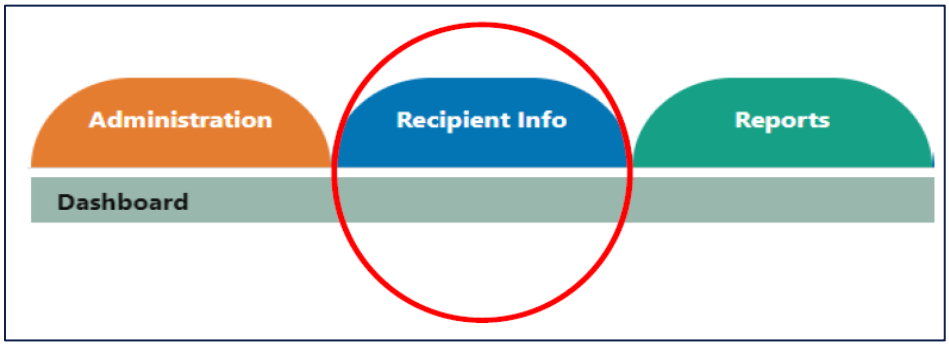
Most recipients are enrolled in either the Primary Care Provider (PCP) or Health Home (HH) programs. Recipients in these programs are required to receive most of their care from their PCP, HH, or designated covering provider (hereafter PCP, HH, and designated covering provider are referred to as "Care Management"). All referrals for recipients in a Care Management program are required to come from the PCP or HH unless otherwise noted in this manual.

Determining if a Recipient in a Managed Care Program

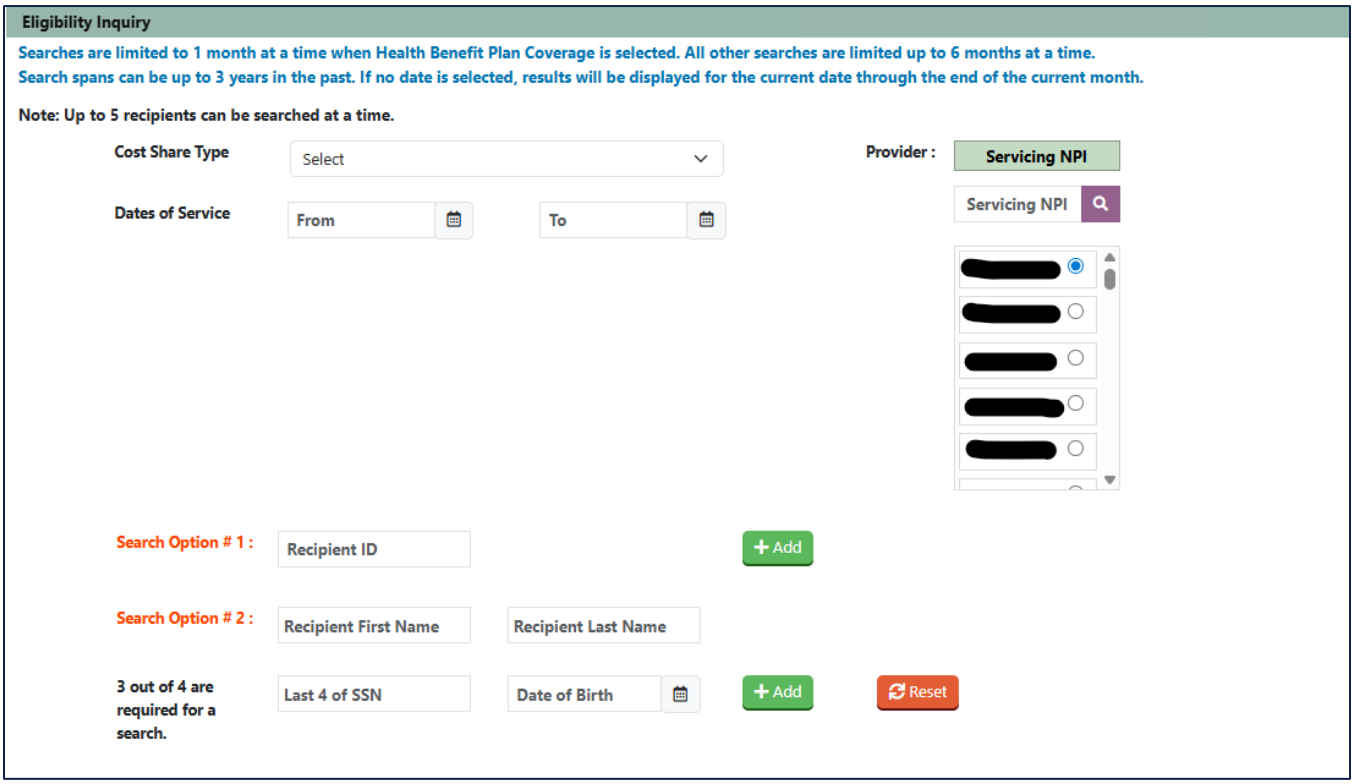
South Dakota Medicaid recommends using the Medicaid Portal (Portal) to verify Medicaid eligibility or to determine if a recipient currently has a provider in either the Primary Care Provider or Health Home Provider program.

Information about how to sign-up or login to the Portal is available here: https://dss.sd.gov/medicaid/portal.aspx.

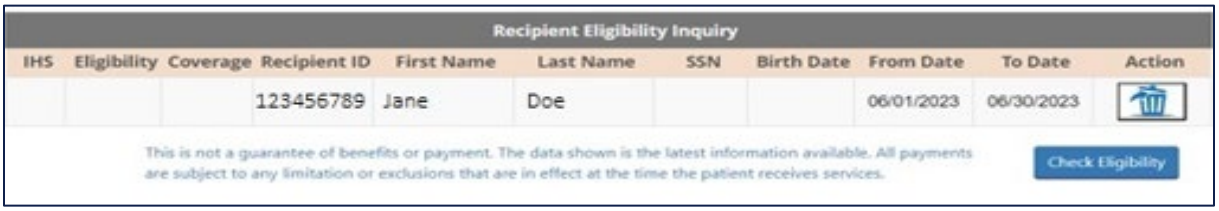
Determine if you have access to the eligibility inquiry functionality in the portal. If you see that you have the Recipient Info half-moon tab as shown below, you can access the information. If you do not see the half-moon tab you will need to request access to that functionality from the individual within your clinic or Health System who has Provider Admin permission in the portal.



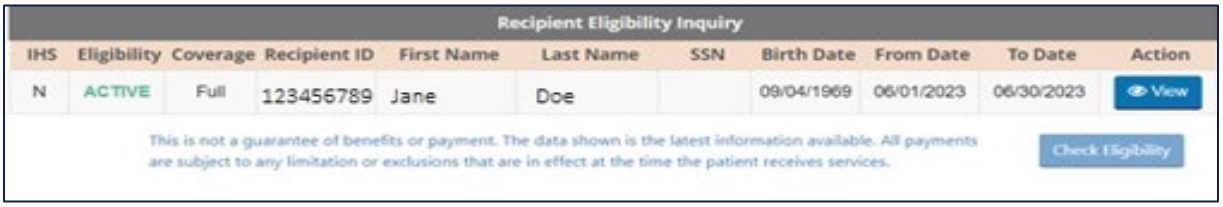
1. Click on the Recipient Info half-moon.
2. Click on Eligibility. The following screen will populate:



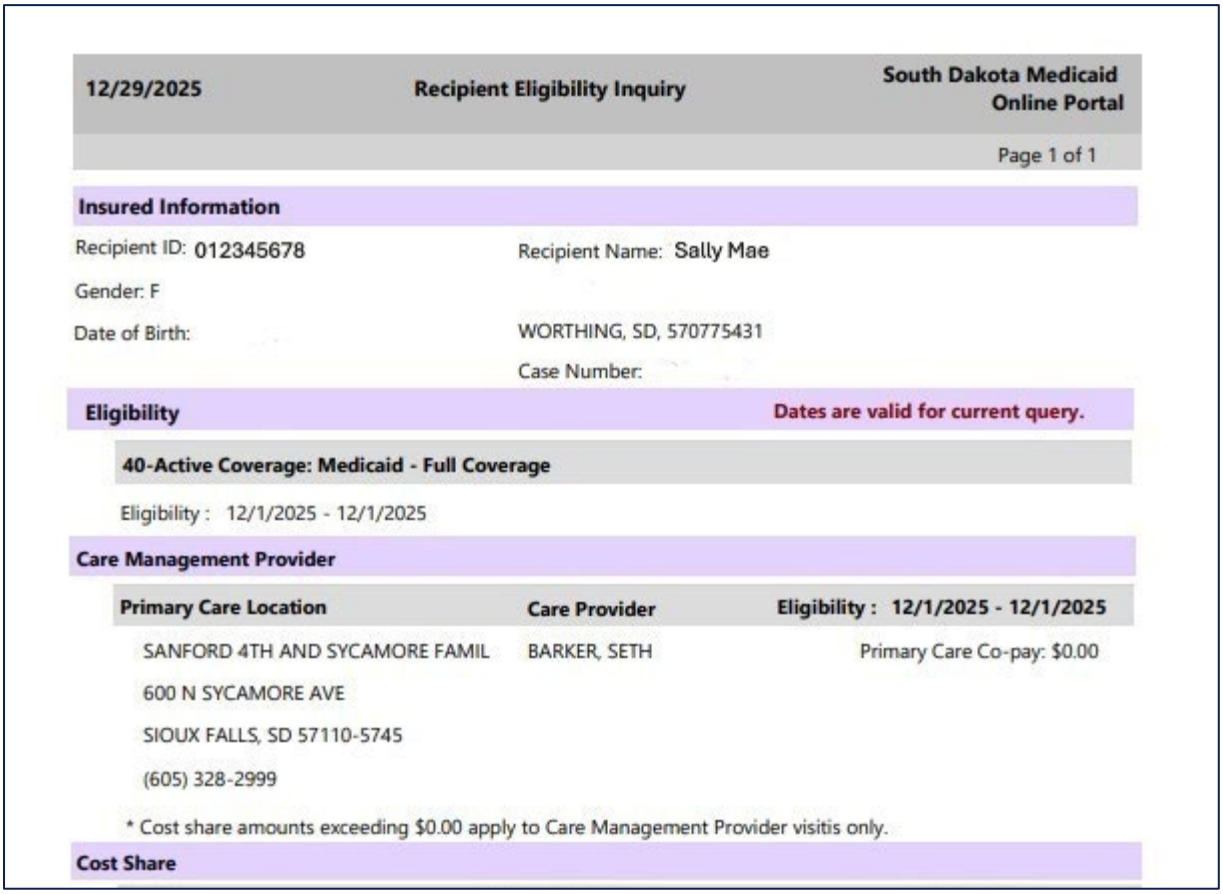
3. Complete the information requested:
   - Enter the Cost Share Type.
   - Enter the Dates of Service.
   - Enter recipient information using either:
     - Search Option 1 - Recipient ID and click the green Add button; or
     - Search Option 2 - First Name, Last Name, and Last 4 of SSN or Date of Birth and click the green Add button.
   - The following screen will populate:



4. Click on the Check Eligibility button. The following screen will populate:



5. The recipient/recipients will appear below the search options. Select View on the recipient you wish to verify. The following Recipient Eligibility Inquiry screen will populate:



Providers should use this screen to verify active eligibility. Providers may review the Primary Care Provider/Health Home Provider section to see if a recipient has or had a provider for the time span for which the search is completed. If there is a provider in this section and a referral is required, make sure a referral is obtained prior to seeing the recipient.

CARE MANAGEMENT RETROACTIVE REFERRALS

Retroactive referrals, including referrals for emergency room visits or urgent care visits, may be given at the provider's discretion. South Dakota Medicaid suggests the recipient has been seen by provider within the past 12 months and/or the provider was aware of the condition for which the recipient sought treatment.

SERVICES REQUIRING A REFERRAL FOR CARE MANAGEMENT RECIPIENTS

The following South Dakota Medicaid covered services must be provided by the recipient's provider or designated covering provider must be referred/authorized by the provider for recipients in the PCP or HH programs:

- Physician/Clinic Services;
- Inpatient/Outpatient Hospital Services;
- Non-Emergent Inpatient Hospital Services;
- Home Health Services;
- Rehabilitation Hospital Services;
- Inpatient Psychological Treatment;
- Durable Medical Equipment Services;
- Ambulatory Surgical Center Services;
- Well-Child Visits (screening);
- Advanced Practice Provider Services
- Residential Treatment;
- Ophthalmology (medical complications, non-routine);
- Physical, Occupational, or Speech Therapy;
- Pregnancy-related Services;
- Community Health Worker Services
- Lab/Radiology Services (at a facility other than the PCP's).

<u>In-House Referrals</u>

In-house referrals are considered implied or otherwise automatic referrals. In-house referrals occur when a recipient is seen by a provider's covering physician for primary care services within the same clinic (e.g., CNP, PA or other covering physician). A referral to a specialty provider within the same clinic who is not enrolled in the applicable care management program is not considered an in-house referral. An emergency department visit performed by a provider within the same clinic as the PCP or HH provider does not constitute an in-house referral and still requires a referral from the recipient's provider.

<u>Further Referrals</u>

A specialty provider may refer the recipient for further medical services. Further referrals can only be provided within the original time frame initially authorized by the recipient's provider (not to exceed one year) and for the original services or condition authorized. The services provided by the specialty provider must be within their scope of practice and covered by South Dakota Medicaid.

SERVICES EXEMPT FROM A REFERRAL FOR CARE MANAGEMENT RECIPIENT

The following covered services are exempt from referrals for recipients in the PCP or HH programs:

- "True" emergency services – if a provider instructs the recipient to seek emergency room care, South Dakota Medicaid will pay for the medical screening examination and other medically necessary emergency room services, without regard to whether the patient meets the prudent layperson standard. Verification of this referral is required, and confirmation must be documented;
- Pharmacy;
- Family planning services;
- Dental/orthodontic services including related services, such as a physical prior to oral surgery;
- Substance use disorder treatment;
- Podiatry services;
- Optometric/optical services (routine eye care);
- Chiropractic services;
- Immunizations;
- Outpatient mental health services or services provided at a Community Mental Health Center provided by an Independent Mental Health Practitioner provided at a Community Mental Health Center;
- Ambulance/transportation;
- Anesthesiology;
- School District Services;
- Birth to Three non-School District Services
- Urgent Care Visits (up to 4 visits a fiscal year, which runs July 1-June 30).
    - For billing instructions please refer to the CMS 1500 Claim Instructions.

INDIAN HEALTH SERVICE (IHS) SERVICES/ TRIBAL 638 REFERRALS

American Indian recipients may choose, but are not required to choose, Indian Health Services (IHS)/ Tribal 638 as their PCP. If they choose a provider outside IHS/Tribal 638 as their PCP, American Indians can still receive services at any IHS/Tribal 638 facility without a referral from their PCP.

PCP is within an IHS/Tribal 638 Facility or Seen at IHS/Tribal 638 Facility

When a recipient whose PCP is within an IHS/Tribal 638 facility or is seen at IHS/Tribal 638 facility who is not their PCP and requires a specialty provider outside IHS/Tribal 638 facility IHS/Tribal 638, a referral is required on behalf of the IHS/Tribal 638 facility. The referral from the IHS/Tribal 638 must be submitted with the claim. This original specialty referral will also cover any subsequent specialty provider referrals that take place outside of the IHS/Tribal 638 facility when the referral from the IHS/Tribal 638 is submitted with the claim.

PCP is Outside IHS/Tribal 638 Facility

When a recipient whose PCP is outside of an IHS/Tribal 638 facility requires a specialty provider who is also outside IHS/Tribal 638 facility IHS/Tribal 638, a referral from the PCP is required.

The referral from the PCP must be submitted with the claim. This original specialty referral will also cover any subsequent specialty provider referrals that take place outside of the IHS/Tribal 638 facility up to one year when the PCP referral is submitted with the claim.

CLAIM INSTRUCTIONS

When submitting a crossover claim for dual eligible Medicaid/Medicare recipients in the Health Home program, if the provider is a type two provider, the claim must still be submitted with the ordering/referring type one provider information on the claim to avoid a denial and to remain in alignment with Medicare guidance. For detailed claim instructions please refer to the applicable claim instructions.

DEFINITIONS

1. "Care Management Programs" a term that encompasses both the Primary Care Provider Program and Health Home Program.

2. "Provider" a Primary Care Provider (PCP), Health Home provider (HH), or designated covering provider.

3. "Recipient" a person who is determined by the department to be eligible for South Dakota Medicaid/CHIP services.

4. "Specialty Provider" a provider to whom the PCP, HH provider, or designating covering provider referred the recipient. In some instances, a specialty provider may be a general practitioner.

QUICK ANSWERS

1. **Can a retroactive referral override claim submission timely filing requirement?**

   No, a retroactive referral cannot override a denial for timely filing.

2. **I referred a patient to a specialist who then referred him/her to another specialist. What do I need to do?**

   It is the responsibility of the patient to ensure the referral is in place prior to their appointment. The referral that was issued by the provider should be communicated to the specialty provider. If the specialty provider refers to another specialty provider, then they will communicate the original referral to the next specialty provider.

3. **Can an American Indian recipient be seen at an IHS/Tribal 638 facility without a referral from their provider?**
   Yes.

4. **If IHS/Tribal 638 is not an American Indian recipient's provider, can IHS/Tribal 638 refer the recipient to another provider? Can I see the recipient without a referral from their PCP?**

   Yes, when IHS/Tribal 638 is unable to treat the recipient because they require more specialized services IHS/Tribal 638 may refer the recipient to a specialty provider. Any further referrals directly related to the original IHS/Tribal 638 referral is also outside of the Care Management referral requirements. Claims for services referred by IHS/Tribal 638 must be submitted with the IHS/Tribal 638 referral information on the claim form.

5. **I have not seen a patient in a long time. Another provider is requesting a referral. Am I required to provide a referral?**

   No, you are not required to provide a referral. Referrals may be made at your discretion. Referrals should be used if you are unable to provide the service to the patient. Please contact South Dakota Medicaid Care Management staff if you would like to inquire about having a recipient removed from your caseload.

   Care Management Staff
   Phone: (605) 773-3495
   Fax: (605) 773-5246
   Email: Medical@state.sd.us

6. **Do I need to use a Medicaid form or "purple card" for Medicaid referrals?**

   No. South Dakota Medicaid does not require providers to use a specific form for referrals. Referrals must contain the information noted in this manual, but do not need to use a specific form.

7. **How do I bill for urgent care services when no referral is needed?**

   To bill for an urgent care service, providers should bill with a "U" or a "2" in Block 10d of the CMS 1500 form. Block 17b may be left blank. When billing for an urgent care service electronically, enter "Y" in 24c (SV109) and use the situational loop 2300 REF*4N*1