



Referral Guide for HMO Patients

Referrals for HMO Patients

There are seven types of referrals for patients with HMO insurance:

- Self- or patient-directed referrals
- Direct referrals (by a physician or provider)
- Non-direct, routine referrals
- Urgent referrals
- Second opinion referrals
- Medicare HMO express
- Referral for investigational or experimental treatment

Self or patient directed referrals: Some HMO insurances have programs that allow patients to make appointments with specific specialists without prior authorization from the medical group. Patients must choose from a list of approved providers and may have co-payments or deductible costs. Specific treatments, follow up visits, and referrals from the provider may require approval from the primary medical group or IPA.

Direct referrals: Axminster Medical Group has a list of direct referrals, which account for the majority of all of our referrals and are pre-authorized by the primary care physician. If the patient is present, the referral coordinator will try to either make the appointment or give the prior authorization form to the patient.

Non-direct referrals: These referrals require review and approval by an Axminster physician. After receipt of pertinent medical records, a decision is made within two working days.

Urgent referrals: Direct urgent referrals are automatically approved. Non-direct urgent referrals are reviewed as soon as possible and within 24 hours.

Second opinion referrals: These referrals are one-time consultations for conditions that include but are not limited to the following:

- Conditions which have not responded to treatment.
- Serious medical conditions with possible bodily impairment
- Conditions where the diagnosis is not certain
- Conditions which may require surgery or other major treatment option

Axminster Medical Group must make a determination if a patient meets the criteria for a second opinion referral within two working days of receiving necessary medical information.

Medicare HMO express referrals: A determination must be made within 72 hours of receipt if the referral meets the criteria for express review.

Experimental or investigational treatment: These referrals are for the evaluation and treatment of serious medical conditions, which are not included in the health plan benefit policies. These referrals are referred directly to the health plan. The health plan arranges a review by an independent body.

Explanation of Terms Used in the Referral Process

Appeals and grievances: A patient or representative may file an appeal if there is disagreement over the decision made by Axminster Medical Group. The patient or representative may file a grievance if they feel that the process leading to the decision or the care was unsatisfactory. Patients should contact the health plans directly for appeals and grievances.

Credentialed providers: To ensure quality care, Axminster's network providers must undergo a thorough process that validates that they have training and expertise in their specialty areas. Providers must be re-credentialed every three years.

Denial/deferral letters: Axminster must provide patients with timely, written notification if a referral is denied/deferred with a clear explanation about the reason for the denial/deferral and include appeals and grievance information.

Eligibility: Axminster Medical Group will check a patient's eligibility for benefits prior to finalizing a referral. Patients must be certain that they maintain their insurance coverage over the entire course of the referral.

Medical necessity: Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. Axminster Medical Group does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Axminster Medical Group does not offer financial incentives to UM decision makers that encourage decisions that result in underutilization.

Prior authorizations: These are issued to credentialed providers after Axminster Medical Group has approved a referral. This authorization states the type of consultation and services that have been approved. This authorization indicates that Axminster Medical Group is responsible for all fees for the approved services minus applicable co-payments or deductibles. Except for these costs, patients should submit any bills to Axminster Medical Group.

Utilization Management Criteria:

These are guidelines or standards on which review decisions are based. Copies of specific criteria are available by mail or fax.

**Please call the Managed Care Department at 1 (800) 411-AXAX 2929
if you have any questions about the referral process.**