Dallas/Fort Worth Referral Pilot Program ends on March 1

Effective March 1, 2023, if a member's plan requires referral, an electronic referral will be required when patient care is directed by the primary care physician (PCP) for all in-network specialists visits, including visits in a hospital clinic.

As you see patient in these plans, keep the following in mind when you request referrals.

- Referrals are only electronic; there are no paper referral forms.
- Referrals need to be requested by the patient's primary care physician (PCP).
- Referrals are not required for direct access services, like routine eye care and obstetric/gynecologic (OB/GYN) services. Refer to the Health Care Professional Toolkit for other direct-access specialties in your area.
- Referrals are not a substitute for services requiring precertification.
- Referrals are authorized immediately and expire after one year.
- For health maintenance organizations (HMO) plans, the first visit from a referral must be used within 30 days to keep it active.
- Referrals do not permit specialists to refer members to another specialist for care. If this is necessary, patients must first get a new referral from their primary care physician to see another specialist.
- Referrals should not be retroactive. We my adjust or deny payment for retroactive referrals.
- Referrals may be issued to an individual specialist using their national provider identifier (NPI) or to a specialty using the taxonomy code:
    - Use our provider referral directory to find a specialist's NPI.
    - You can find a list of taxonomy codes on the same website you use for other electronic transactions, or sign up to access our provider website.
    - For taxonomy referrals, remind patients to see a specialist in their network. Patients can find a participating specialist on their secure member website.
- Please remember to direct patients to in-network providers. Directing patients to nonparticipating providers will require prior authorization from Aetna to be covered on an in-network basis. Failure to pre-authorize services, including out-of-network care, could result in a denial of payment or a reduction in the benefit payable in addition to increased costs for your patients.
- Diagnosis and procedure codes are not required. But a referral without a procedure code defaults to a consultation only.
- Use 99499 for consult and treatment; it allows the specialist to examine and treat the patient, and it covers automatic studies.

More information

For more information on electronic referrals, see our Office Manual for Health Care Professionals. Refer to our Precertification and Referral Guide to see if a service requires precertification.