Provider Referral FAQs

Q. What is a referral and when is one required?

A. A referral is a CGHC form that an in-network provider must complete prior to the member receiving out-of-network services. The Referral Form must be submitted by an in-network provider to CGHC for review. The member, the in-network referring provider and the out-of-network provider will receive written confirmation of approval or denial of the requested services. (Note: an out-of-network referral will only be approved in situations where the required medical necessary services cannot be performed by an in-network provider.)
Services received without an approved referral will be denied and the payment will be the responsibility of the CGHC member. A referral is not required for urgent or emergency services.

Q. Where can we find the Referral Form?

A. You may obtain the form on our website at **www.CommonGroundHealthcare.org/For-Providers/Resources** or you may call Member Services at **877.514.2442 and** they will email the form to you.

Q. Can the member or the out-of-network provider complete the Referral Form?

A. No, only an in-network provider can complete and submit the Referral Form. If we receive a Referral Form completed by the member or out-of-network provider, we will return the form and send a letter notifying them of the correct process.

Q. Is there a certain type of in-network provider who can complete the Referral Form?

A. The referral should be completed by an in-network MD or DO. It should typically be a primary care physician but it could also be a specialist (i.e. cardiologist).

Q. Who reviews the Referral Form at CGHC?

A. CGHC's Chief Medical Officer reviews the Referral Form and either approves or denies the referral. You may be asked to provide additional information, including medical records, to support the referral. The Chief Medical Officer may also contact you by telephone to discuss the member's condition and proposed treatment.

Q. How long does it take for CGHC to review a Referral Form?

A. It will take up to 7 business days for a non-urgent referral and up to 72 hours for an urgent request. If the request is urgent and a prior authorization is also required for the service, please note that both the referral review and prior authorization review must be completed within the 72 hours.

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Q. Where do we submit the Referral Form?

A. You may submit the Referral Form using one of the following secure methods:

- Email to: CGHCReferrals@CommonGroundHealthCare.org. Please encrypt the email to ensure patient information is protected.
- Fax to: 262.754.9690
- Mail to: CGHC, Attn: Referrals, PO Box 1630, Brookfield, WI 53008-1630

Q. What if the out-of-network service also requires Prior Authorization? How will that work?

A. It is important to note that a referral is separate from a prior authorization. A referral provides approval for the member to utilize an out-of-network provider and the prior authorization process reviews the treatment to ensure it is medically necessary. Optum will continue to perform all prior authorization services.

CGHC will need to receive the written Referral Form from the in-network provider and approve it before Optum will begin the prior authorization process. If the Chief Medical Officer approves the referral, the Referral Form will be submitted to Optum with instructions to begin the prior authorization process.

If an out-of-network provider contacts Optum for a prior authorization, Optum will inform the provider that out-of-network services cannot be authorized until a written referral is submitted to CGHC by the in-network provider and then approved by CGHC (excluding emergency and urgent care).

Q. What happens if a member obtains CGHC referral approval but they don't get a prior authorization?

A. The process will be similar to what happens today. The claim will be denied for failure to prior authorize; however, Optum will perform a retrospective review if the required information is submitted post claim. If Optum finds the procedure was medically necessary, CGHC will reprocess the claim applying the prior authorization penalty (50% of the allowable amount up to $1500) to the claim.

Q. What happens if the referral is denied?

A. CGHC will send a letter to the member and both providers notifying them. If the member still undergoes the service, the claim will be denied.

Q. Are there services that will generally not require a referral?

A. Yes. Here is a list of services that will never require a referral:

- Urgent care outside of CGHC's service area
- Emergency care inside or outside of CGHC's service area

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Here is a list of services that may not require a referral, however, we recommend that you still obtain one in order to assist your patient with managing costs since the maximum allowable fee will still apply and it is possible, in many cases, for us to minimize additional costs:

- Maternity care for new members in their 3rd trimester of pregnancy
- Transplants
- Dialysis
- Certain durable medical equipment purchases that cannot be delivered/dispensed by an in-network provider
- For full-time students enrolled in Institutes of Higher Learning seeking behavioral health/substance abuse disorder treatment outside of CGHC's service area but within the State of Wisconsin (see Dependent Children section below)