VENTURA COUNTY HEALTH CARE PLAN

Utilization Management Policy & Procedure:
Standing Referrals to Specialists
Requirement: UM 011
Effective:
Revised/Reviewed: August 2009, May 2011, January 2012, February 2013, February 2014, February 2015, February 2016, February 2017, February 2018, November 2018, February 2019

Background:

AB1181 and, separately, AB 2168 were introduced to address the consumer concern that members must return to their PCP on a repeated basis in order to continue to see a specialist for an ongoing problem. Based on these legislations, Section 1374.16 of the Health and Safety Code and Section 14450.5 of the Welfare and Institutions Code which apply to all health care service plan operations, were modified for compliance. Essentially, these laws require health plans to establish specific procedures that meet specific standards for ongoing referrals for healthcare services. AB1181, relating to general chronic medical conditions became effective on and after January 1st, 1999. AB2168 relating to AIDS/HIV became effective on and after January 1st, 2001 and incorporates AIDS and HIV disease as part of the life-threatening generative conditions or diseases.

Policy

VCHCP (The Plan) supports and promotes the provision of standing referrals for members with certain chronic conditions or diseases, including but not limited to HIV and AIDS that require specialized ongoing care. The intent of this policy is to design a framework enabling Primary Care Physicians to request:

- Standing referrals to a specialist for members requiring continuing specialty care over a prolonged period of time, and

- Extended access to a specialist for an enrollee who has a life threatening, degenerative or disabling condition that requires coordination of primary care by a Specialty Care Physician (SCP). The SCP is designated to serve as the coordinator of an enrollee's care.

VCHCP supports the development and use of treatment plans to be used in conjunction with the above standing referrals. This treatment plan should be requested using the plan's Treatment Authorization Request (TAR) form if deemed to be medically necessary by the member's PCP and SCP in question.

Treatment plans must describe the course of care. After receiving standing referral approval, the specialist is authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the PCP. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, VCHCP will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria. [Ref.: CA Health & Safety Code 1374.16(g)].

If VCHCP does not have an identified HIV/AIDS specialist, the member will be referred to contracted tertiary providers. Determinations based on medical appropriateness are only made by a physician holding an unrestricted license in the State of California. Requests for authorization for standing referrals to specialist are reviewed and the decisions and notifications must be made within the time frames appropriate to the condition of the member (e.g., urgent,

non-urgent, concurrent), not to exceed 3 working days of the date that all necessary information is received. [CA Health & Safety Code 1374.16(c)].

PROCEDURE

I. Specialty Referrals

1. Requests for standing referrals will be made either by the member's PCP, SCP or the member.
2. The request will be reviewed and agreed to by the PCP and SCP and submitted to the Plan
3. Standing referral requests include:
   - Member diagnosis
   - Required treatment
   - Requested frequency and time period
   - Relevant medical records
4. Extended Access to Specialty Care
   - The member's PCP or SCP will make request for extended access to specialty care in which the SCP will coordinate the members' primary care.
   - Requests will indicate life threatening, degenerative, or disabling factors involved in the request.
   - Requests will be reviewed and agreed to by both the PCP and SCP and submitted to VCHCP.
   - The requesting PCP or SCP will indicate the health care services the SCP will be managing and detail those that will be managed by the PCP.

II. Plan's Review and Determination and Authorization Process:

1. The Plan's review and determination will be provided within the current regulatory UM timeless standards of receiving necessary records and information.
2. Communication of determination to the member and involved practitioners will be provided within the current regulatory UM timeless standards of receiving necessary records and information.
3. The approval may include:
   - Number of visits approved.
   - Time period for which the approval will be made.
   - Extension request process.
   - Standard reporting required from the SCP to the PCP and/or VCHCP's Medical Director.
4. The Plan's staff will provide notification to the member and the involved physicians indicating:
   - The terms and conditions of the approval, and
   - Process for requesting further referrals, if needed.
5. If the request was denied or modified, the member and the involved physicians will be informed of the reason for denial as well as description of the appeal process.
6. The Plan's staff shall notify involved physicians that prior to services being provided, patient eligibility must be determined.

Once the determination is made regarding the need for the standing referral, the referral to the specialist shall be made within four (4) business days.

See UM Policy: Treatment Authorization Request: Authorization Process and Timeline Standards for details of authorization process and timeline standards.

III. Out-of-Network Providers

1. The Plan is not required to refer members to out-of-network providers unless appropriate specialty care is not available within VCHCP's network.
2. The Plan's Medical Director and PCP will consult and both shall determine whether an appropriate in-network specialty provider is available.

IV. Medical Necessity for Authorization Requests and Treatment Plans

- The Plan's Medical Director or designee reviews and oversees the standing/extended access to specialty care referral process in consultation with the PCP and SPC
- The Plan's Medical Director or physician designee supervises each denial and communication with the requesting physician.
- The Plan's Medical Director or designee communicates all denials to the physicians who have requested or are involved in the request.
- Plan's Medical Director or designee assures that approvals for standing referrals are authorized in consultation with the PCP and SPC based upon the need for continuing care and will be reasonably approved when indicated.

V. Extended Specialty Access Guidelines by Medical Category and Condition

VCHCP will provide the PCPs and SPCs the following:

- Process for submission of Standing or Extended Specialist Referral Request to VCHCP. The Treatment Authorization Request Form (TAR) will include the language informing the SPCs of the option to request for a standing referral if they are caring for members who need continuing care and who require care over a prolonged period of time. Additionally, the TAR will contain the information on the timeframe for the length of authorization of standing referrals which is 180 days (see TAR form).
- The Plan's authorization letter will include the 180 days' timeframe authorization for standing referrals.
- VCHCP will educate primary care and specialty physicians with regards to AB 1181 and the internal policies and procedures in place to ensure compliance with this legislation.

VI. Tracking

1. The Plan will track all requests for standing and extended access referrals.
2. The tracking will include:

- Documentation of the requesting physician
- Nature of the request including the member's diagnosis, date, health plan, and referral determination
- Appeal outcome, if applicable

VII. Appeals/Grievance

Appeals from denials by VCHCP will be processed for resolution within the established guidelines for appeals and grievance resolution.

Attachments: See UM Policy: Treatment Authorization Request: Authorization Process and Timeline Standards for details of authorization process and timeline standards.

A.

B. References:

C. Reviewers: Utilization Management Committee; Medical Director; QA Manager; Health Services Director

Reviewed/Revised by**:** Lita Catapang, RN & Albert Reeves, MD

- Committee Review:
  - UM: August 2009; QAC: August 2009

Reviewed/Revised by: Faustine Dela Cruz, RN & Albert Reeves, MD

- Committee Review:
  - UM: May 12, 2011; QAC: May 24, 2011

Reviewed/No Changes by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD

- Committee Review:
  - UM: February 9, 2012; QAC: February 28, 2012

Reviewed/No Updates by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD

- Committee Review:
  - UM: February 14, 2013; QAC: February 26, 2013

Reviewed/No Updates by: Linda Baker, RN & Catherine Sanders, MD

- Committee Review:
  - UM: February 13, 2014; QAC: February 25, 2014

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- Committee Review:

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Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/9/17	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/8/18	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
9/13/18	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	See UM Policy: Treatment Authorization Request: Authorization Process and Timeline Standards for details of authorization process and timeline standards.
2/14/19	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review