ProCare MSO

Original Date Approved by UM Committee:	5/28/2013	**Policy No.**	UM 012
Last Date Approved:	12/08/2015	**Internal:**	☒
Last Date Revised:	10/26/2015, 12/28/2020	**External:**	☒
Last Date Reviewed	12/04/2017, 12/08/2019, 12/28/2020, 12/08/2022	**Former #**	New
Signature UM Committee Chair	Tuan Nguyen, MD (signature on file)		

SUBJECT: Standing Referrals/Extended Access To Specialty Care

SCOPE: ProCare MSO Clinical Staff and all Contracted Providers

PURPOSE: To establish a clearly defined process for ensuring PCPs provides for standing referrals to allow specialists to act as Primary Care Physicians ("PCP") "when an enrollee has a medical condition or a disease that requires specialized medical care over a period of time."

DEFINITIONS:

A Standing Referral, for the purpose of this policy, is defined as a referral that allows the member to obtain services from a specialist for certain length of time (such as six (6) months), without having to obtain additional referrals.
A standing referral is a referral made by the PCP for more than one (1) visit to a specialist or specialty care center as indicated in an approved treatment plan for a particular diagnosis.
The following conditions may qualify:

- Primary Care Physician determines, in consultation with a physician, that you need continuing care from the physician;
- Patient has a life threatening, degenerative, chronic, or disabling Condition or disease that requires specialized medical care; and
- The Participating Physician or Specialty Treatment Center has expertise in treating the life threatening, degenerative, chronic, or disabling disease or Condition.

POLICY: ProCare MSO will authorize a Standing Referral to a participating SCP or Specialty Care Center when a request is deemed necessary by ProCare MSO

medical review for diagnosis, treatment and management of a complex diagnosis, life-threatening, degenerative or disabling condition/disease.

PROCEDURE:

1. **Requesting a Standing Referral**:

    a. When authorizing a standing referral to a specialist requiring more than one visit to a specialist or specialty care center for treatment of a condition, the enrollee will be referred to an the specialized including an HIV/AIDS specialist, the request is made by the member's PCP, Specialist or the member.
    b. Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved.
    c. Responses regarding decisions to deny, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated in writing, and to providers initially by telephone or fax, except when decisions are rendered retrospectively. The written communication include:
        - clear and concise explanation of the reasons for the decision;
        - description of the criteria/guideline used;
        - clinical reasons for decisions regarding medical necessity
        - name and direct telephone number or extension of health care professional responsible for the determination
        - information as to how the enrollee can file a grievance
        - appeals process
    d. The referral shall be made pursuant to a treatment plan approved by PROCARE in consultation with the PCP, the specialist and the member if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by PROCARE (or the health plan).
    e. The referral request is to be made to an PROCARE (or health plan) contracted specialist, HIV/AIDS specialist, or specialty care center unless there is no specialist within the Plan network that is appropriate to provide treatment to the enrollee, as determined by the PCP in consultation with the Medical

Director, then the referral will be made to a non-contracted provider.

f. Standing referral requests will include:
   1) Diagnosis
   2) Required treatment
   3) Requested frequency and time period
   4) Relevant medical records

2. **Review and Determination:**

   a. The referral request will be reviewed consistent with PROCARE criteria and guidelines.
   b. The review will be conducted by the PROCARE IPA/Medical Group Medical Director, his/her designee physician, or a Specialty Physician Consultant.
   c. The review will be conducted by the PROCARE IPA/Medical Group Medical Director, his/her designee physician, or a Specialty Physician Consultant.
   d. The standing referral determinations shall be made within three (3) business days of the date the request and all appropriate medical records and other items of information necessary to make the determination are provided.
   e. Once the determination is made, the referral to the specialist will be made within 4 business days of the date of the proposed treatment plan, if any, is submitted to the Medical Director or his/her designee. Services shall be authorized as medically necessary for proposed treatment, of a duration not to exceed one year at a time, utilizing established criteria and consistent with benefit coverage.
   f. Once the specialist or specialty care center has been approved to coordinate the member's health care, the organization approves specialist to provide heath care services within the specialist's area of expertise in the same manner as it approves the enrollee's primary care services, subject to the terms of the treatment plan. The approval shall include:
      1) Number of visits approved
      2) Time period for which the approval will be made
      3) A clause specifying: "patient eligibility to be determined at the time services are provided".

3. Specialty Care Physician (SCP) – PCP Communication Guidelines:
   a. The SCP will provide information to the PCP on the progress and or any significant changes in the member's condition.
   b. The PCP will maintain the communicated information in the member's medical records.

c. The PCP shall retain responsibility for basic case management/coordination of care unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the PCP contract.

4. **Tracking:**
    a. Standing referral requests will be entered into EzCap and will include:
        - date received
        - Date closed
        - Decision type
        - Authorization number
        - Concise description of the services requested
        - Description of services authorized
        - Quantity authorized
        - Documentation of clinical information as entered by the provider on the referral request
        - Time period for which the authorization is approved

    b. A hard copy of the referral request along with the medical information submitted will be maintained on file within the Ezcap system under the member's record.

FORMS:

REFERENCES: AB 1181, CFR Title 42, Section 422.112 of the 1997 Balanced Budget Act, Section 1374.16 of the Health and Safety Code and Section 14450.5 of the Welfare and Institution Code, and AB 2168.

Access Standards for Physician Appointments	
Medical Authorization/Referrals	
Routine Appointments	Within thirty (30) days
Urgent (non-emergent) Appointments	Within twenty-four (24) hours
Emergent / After-hours	Immediate (24/7)
Behavioral Health Authorization/Referrals	
Routine Appointments	Within ten (10) business days
Urgent (non-emergent) Appointments	Within forty-eight (48) hours
Non-life-threatening Emergent / After-hours	Within six (6) hours
Member Services Calls	During normal business hours