ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-056
Policy Name	Standing Referrals
Department Name	Health Services
Department Officer	Chief Medical Officer
Policy Owner	~~Director of Clinical Services~~Director Utilization Management
Line(s) of Business	Medi-Cal and Group Care
Effective Date	3/01/2018
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/18/2023~~TBD
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

The Alliance provides standing referrals to specialists for enrollees who require continuing specialized medical care over a prolonged period of time as part of ongoing ambulatory care or due to a life-threatening, degenerative, or disabling condition. Services shall be authorized as a medically necessary proposed treatment identified as part of the enrollee's care or treatment plan utilizing established criteria and consistent with benefit coverage. Requests can be made by a member, Primary Care Physician (PCP) or specialist. The enrollee may receive a standing referral to a specialist or S~~s~~pecialty C~~c~~are C~~c~~enter (SCC), in accordance with applicable rules and regulations in accordance with H&S Code section 1374.16

POLICY

1. The Alliance shall maintain a referral management process and may delegate the referral management process to delegated entities.
   a) Delegated Entities shall maintain policies and procedures for referral management that includes reviews of requests for standing referrals for enrollees who require continuing specialty care or treatment for a medical condition or disease that is life threatening, degenerative, or disabling.

2. The Alliance shall establish and implement a procedure to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the Primary care Physician (PCP), in consultation with both the specialist, if any, and The Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or SCC.
   a) The Alliance may require the PCP to submit a treatment plan during the course of care or prior to the referral from the enrollee as determined by the Medical Director.

b) If a treatment plan is necessary in the course of care and is approved by The Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.
c) A treatment plan may be deemed unnecessary if The Alliance approves a current standing referral to a specialist.
d) The treatment plan may limit the number of visits to the specialist, limit the period of time during which visits are authorized, or require that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

3. The Alliance shall establish and implement guidelines for standing referral requests for enrollees that required specialized medical care over a period of time and who have a life-threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for the purpose of having specialist coordinate he enrollee's health care.
   a) The referral shall be made if the PCP, in consultation with the specialist or SCC, and Medical Director, determines that the continued specialized medical care is medically necessary for the enrollee.
   b) The Alliance may require the PCP to submit a treatment plan during the course of care or prior to the referral for the enrollee, as determined by the Medical Director.
   c) If a treatment plan is deemed necessary in the course of the care and is approved by The Alliance, in consultation with the PCP, specialist. SCC and the enrollee, a referral will be made accordance with the treatment plan.
   d) A treatment plan may be deemed unnecessary if The Alliance approves the applicable referral to a specialist or SCC.

Formatted: Indent: Hanging: 0.23"

4. Standing referral to a specialist or SCC are provided within The Alliance's network to participating providers, unless there is no specialist or SCC within The Alliance's network that is appropriate to provide treatment to enrollee, as determined by the PCP in consultation with the Medical Director and as documented in the treatment plan.

5. Authorization and Referral Processes for Standing Referrals
   a) Authorization determinations for specialty services shall be processed accordance with Alliance's and/or its delegated entity's policies and procedures for referral management and within required time frames for standing referrals, as described in this policy, as described in AAH policy UM-057 Authorization Service Requests, and according to applicable regulations.
      i. Standing Referral authorization requests will be processed as a prospective review (a prior authorization request,) to approve, deny, modify or delay based on medical necessity. (HSC 1367.01)
      ii. Services shall be authorized as medically necessary for proposed treatment identified as part of the enrollee's care or treatment plan utilizing established criteria and consistent with benefit coverage.
      iii. Determinations (authorized, denied, or modified) for a standing referral shall be made within three (3) business days from the date the request is made by the enrollee or the enrollee's PCP and all appropriate medical records and other information necessary to make the determination are received by The Alliance or delegated entity, as applicable.
      iv. Once the determination is made, the request for the standing referral shall be processed within four (4) business days of the date of the proposed treatment plan (if any), is submitted to a physician reviewer.

v. The duration of an approved standing referral authorization shall be determined by the Medical Director, as medically appropriate, but shall not exceed one year.

~~v.~~vi. Upon expiration of the approved standing referral authorization, the PCP or enrollee may submit a new request to renew the standing referral authorization which shall be evaluated with this policy.

6. Timeliness Standards:

a) Determinations within:
   i. Three (3) business days from receipt of request for standing referral.

b) Processed Within four (4) business days of the date of the proposed treatment plan, if any, is submitted to the Medical Director.

Notification – UM staff will generate the letter of notification of the decision to the Member, PCP and Specialist within:

c)
~~i.~~ i. Two (2) calendar days of the final determination for routine request

PROCEDURE

~~1.0~~1. Standing Referral Requests managed by delegates will be processed using the Delegated Entities UM Policy for Authorizations. Staff procedures may differ from The Alliance UM processes but Delegates will administer to the regulatory requirements.

2.~~.0~~ Requests for a standing referral are initiated by the PCP/Specialist/Member after the Specialist and PCP agree on the Treatment Plan.

3.~~.0~~ Referral requests are received via fax, online or phone through the UM designated mode of communication and processed by the Alliance's Utilization Management (UM) department.

4.~~.0~~ UM department will process the referral request using guidelines from UM Authorization policy and procedure. The case will be routed to UM Nurse for review.

5. Upon receipt of a request for Standing Referral/Extended Specialty Referral, after the initial consultation has been completed, the UM Nurse will review the request and assures that the pertinent information is included in the referral:

~~5.0~~ a) Member diagnosis
~~5.1~~ b) Required treatment
~~5.2~~ c) Requested frequency and time period
~~5.3~~ d) Relevant medical records
~~5.4~~ e) Other referrals, evaluation, or procedures, if any
   ~~5.4.1~~ i. If additional information is needed the UM Nurse will request and allow the PCP/Specialist sufficient time to submit for determination per UM

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Normal, Indent: Left: 0.35", Right: 0.29", No bullets or numbering, Tab stops: 0.65", Left + Not at 1.16" + 1.16"

Formatted: Indent: Left: 0.1", Hanging: 0.2", Right: 0.1"

Formatted: Indent: Left: 0.1", Hanging: 0.1"

Formatted: Indent: Left: 0.1", Hanging: 0.1", Right: 0.1"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Normal, Left, Indent: Left: 0.5", No bullets or numbering

Formatted: Normal, Indent: Left: 1", No bullets or numbering

Policy – Timeliness of UM Decision Making.

6.~~0~~ UM Nurse will confirm the Treatment Plan includes review and signature of the PCP or Specialist validating the requested services. The UM Nurse forwards the completed request to the Medical Director for final determination.

7. ~~7.0~~ Medical Director will review each request to ensure the Treatment Plan is appropriate and supported by the PCP and Specialist.

Formatted: Outline numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.1" + Indent at: 0.35"

8.~~0~~ Medical Director will forward the case with the final determination to the coordinator of record for appropriate notifications to PCP/Specialist and Member.

~~9.0~~9. Annual Renewals

~~9.1~~a) Standing referrals are valid for up to one calendar year from the date of the latest determination.

~~9.2~~b) UM Staff will process authorizations with the approved number of visits based on the approved Treatment Plan.

~~9.3~~c) Requests for renewals to Standing Referrals are reviewed using the guidelines of this policy and the latest clinical information with a new Treatment Plan from PCP and Specialist.

~~10.0~~10. Preventive Care:

~~10.1~~a) The specialty care provider is responsible for addressing the member's preventive health while the member is under his/her care for primary and specialty care services. Preventive services such as comprehensive history and physical exam, immunization, preventive screenings, and counseling, etc. must be addressed and be provided according to the periodicity guideline for preventive care for both adults and children, per recommendation by the US Preventive Services Task Force (USPSTF).

Formatted: Font: 12 pt

Formatted: Left, Indent: Hanging: 0.48", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 9 + Alignment: Left + Aligned at: 0.35" + Indent at: 0.6"

Formatted: Left, Indent: Left: 0.6", Numbered + Level: 2 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.85" + Indent at: 1.1"

Formatted: Indent: Left: 0.6", Numbered + Level: 2 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.85" + Indent at: 1.1"

Formatted: Font: 12 pt

Formatted: Left, Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 9 + Alignment: Left + Aligned at: 0.35" + Indent at: 0.6"

Formatted: Left, Indent: Left: 0.54", Hanging: 0.31", Numbered + Level: 2 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.85" + Indent at: 1.1"

DEFINITIONS / ACRONYMS

~~1.0~~ **Benefits Determination:** A denial of a requested service that is specifically excluded from a Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

~~2.0~~ **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcomes.

~~3.0~~ **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

~~4.0~~ **Medically Necessary (Group Care Program):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

(Group Care Program Evidence of Coverage)

~~50~~ **Medically Necessary (Medi-Cal Program):** means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that~~t~~

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Font color: Custom Color(RGB(35,35,35))

Formatted: Normal, Left, No bullets or numbering

Formatted: Font: 12 pt

a medical Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

- 5.1 Consistent with nationally accepted standards of medical practice:
  - 5.1.1 "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.
  - 5.1.2 For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
  - 5.1.3 For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
    - 5.1.3.1 When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1.

6.0 **Medical Necessity Determination** means UM decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services; and care or service that could be considered either covered or non-covered, depending on the circumstances.

7.0 **Member** means any eligible beneficiary who has enrolled in the Alliance and who has been assigned to or selected a Plan

8.0 **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with AAH

9.0 **Prior Authorization or Prospective Review**: A type of Organization Determination that occurs prior to services being rendered.

Provider means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

10.0

- 10.1 NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services, but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word

Formatted: Indent: Left: 0"

Formatted: Font: 12 pt, Font color: Custom Color(RGB(35,35,35))

Formatted: Font: 12 pt

Formatted: Left, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Bulleted + Level: 2 + Aligned at: 0.75" + Indent at: 1"

Formatted: Font: 12 pt, Font color: Custom Color(RGB(35,35,35))

Formatted: Bulleted + Level: 3 + Aligned at: 1.25" + Indent at: 1.5"

Formatted: Font: 12 pt

Formatted: Font: 11.5 pt, Font color: Custom Color(RGB(34,34,34))

Formatted: Font: 11.5 pt

Formatted: Normal, Left, No bullets or numbering

Formatted: Left, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Provider.

~~11.0~~ **Specialty Care Center** means a center that is accredited or designated by an agency

Formatted: Indent: Left: 0", Hanging: 0.5"

of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

~~12.0~~ **Standing Referral** means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

~~13.0~~ **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources

Formatted: Indent: Left: 0", Hanging: 0.5"

Formatted: Normal, Indent: Left: 0", Hanging: 0.5", Right: 0", Space Before: 0 pt

AFFECTED DEPARTMENTS/PARTIES

Utilization Management

RELATED POLICIES AND PROCEDURES

1. UM-001 – Utilization Management
2. UM-051 – UM Timeliness Standards
3. UM-057 – Authorization Request Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

Formatted: Indent: First line: 0.5"

REVISION HISTORY

3/01/2018, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023, 04/25/2024

REFERENCES

1. California Health and Safety Code – HSC § 1374.16
2. DHCS Contract Exhibit A, Attachment 9, Access and Availability, Section 7
3. California Welfare and Institutions Code Section 14450.5
4. California Health and Safety Code – HSC § 1367.01

MONITORING

- Delegated Medical Groups
  - The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
  - The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
    - Internal Monitoring
      - The Utilization Management Department, on a routine basis, reviews:
    - Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
    - Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
    - Quarterly reports of authorizations and claims for non-network specialty referrals and standing referrals

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering