blue california
Promise Health Plan

Policy Title: Standing Referral/Extended Access to Specialty Care		POLICY #: 70.2.32 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 1/99	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 3/21**	

PURPOSE

To outline a process for Blue Shield of California Promise Health Plan (Blue Shield Promise) members with a condition or disease that requires specialized medical care over a prolonged period of time.

To obtain a standing referral for ongoing extended access to a specialist or specialty care center for the treatment of a disabling, life threatening or degenerative condition, in accordance with Health and Safety Code, Section 1374.16.

To establish and implement a standing referral process for HIV/AIDS patient.

POLICY

Blue Shield Promise shall provide for a standing referral to a specialist if the primary care physician in consultation with the specialist, if any, and Blue Shield Promise's Medical Director or designee, determines that an enrollee needs continuing care for his/her chronic, disabling condition.

The referral shall be made pursuant to a treatment plan approved by Blue Shield Promise in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of care.

A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by Blue Shield Promise or its contracting provider, medical group or IPA.

The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.

A request for a standing referral to a specialist may be initiated by the member, the primary care physician (PCP), or the specialty care physician (SCP), when the member has a disabling, life threatening or degenerative condition, including human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS), or any condition or disease that requires specialized medical care over a prolonged period of time.

Standing referrals shall be made to those specialty providers that have demonstrated expertise in treating the condition and the treatment of the condition has been deemed to be medically necessary by Blue Shield Promise Health Plan.

DEFINITIONS:

Specialty Care Center – means a center that is accredited or designated by an agency 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 assigned.

HIV/AIDS Specialist – means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the State of California who meets any one of the following 4 criteria:

A. Credentialed as an "HIV Specialist"
B. Board certified, or has earned a Certificate of Added Qualification in the field of HIV medicine
C. Board certified in the field of infectious diseases
D. Meets the qualification stated in 28 California Code of Regulations 1300.67.60 (e)

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.

PROCEDURE

I. Requesting a Standing Referral:

a. When authorizing a standing referral to a specialist requiring care by a physician with a specialized knowledge of HIV medicine, the enrollee shall be referred to an HIV/AIDS specialist.
b. The request shall be made by the member's PCP, specialist or the member.
c. The referral request shall be made to a Blue Shield Promise 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 Chief Medical Officer, then the referral shall be made to a non-contracted provider, as outlined in Policy & Procedure 70.2.16 Non Contracted Providers.
d. Standing referral requests shall include:
    i. Diagnosis
    ii. Required treatment plan
    iii. Requested frequency and time period
    iv. Relevant medical records

II. Decision Timeframes:

a. The determination shall be made within three (3) business days of the date the request for the determination is made by the member or the member's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided.
b. Once the determination is made, the referral to the specialist shall be made within 4 business days of the date of the proposed treatment plan, if any is

submitted to the physician reviewer. 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.

c. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.
d. The approval shall include:
    i. Number of visits approved
    ii. Time period for which the approval will be made
    iii. Clause specifying: "patient eligibility to be determined at the time services are provided"

III. Specialty PCP Communication Guidelines:

a. The SCP shall provide information to the PCP on the progress and or any significant changes in the member's condition.
b. The PCP shall 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.

IV. Electronic Adjudication for HIV and AIDs Referrals:

a. There are distinct codes that fall under HIV and AIDS
    i. HIV Codes:
        1. 042
        2. 795.71
        3. V08
        4. V65.44
    ii. AIDS Codes
        1. 042
        2. 136.3
b. Upon identification of HIV/AIDS request for specialty services to HIV/AIDS specialist, the UM staff entering the referral shall flag it as a standing referral for HIV/AIDS and the authorization shall be entered with the following elements to comply with creating a standing referral for this condition:
    i. Date of the referral
        1. The referral request is effective 1 year. Upon the expiration, the referral shall be automatically renewed, contingent upon the enrollee's eligibility
    ii. Number of referrals
        1. The enrollee can avail himself of the visit to the infectious disease physician or immunologist, determined to be HIV/AIDS specialist, as often and as many times as necessary (99 visits per year). The referral is renewable every year, as long as the member is eligible.
    iii. Level of Care
        1. The UM staff shall enter the initial referral request as a level 4-5 office visit. Succeeding visits shall be entered as level 3 office visit.
c. On a monthly basis, the data analyst shall run a report of referral encounters to determine if the referral is going to expire; in which case, the referral shall be automatically renewed, as long as the enrollee is eligible.

V. Reporting for HIV and AIDS:

a. This report shall be shared with the Claims Department to cross-reference the payments to the HIV/AIDS specialist.
b. For purpose of case management, a separate report shall be generated for HIV/AIDS cases. This report shall determine if an HIV case has converted to a full-blown AIDS.

VI. Reporting for all standing referrals:

a. Standing referral requests shall be entered into the MHC system and shall include:
    i. Date received
    ii. Date closed
    iii. Decision type
    iv. Authorization number
    v. Concise description of the services requested
    vi. Description of services authorized
    vii. Quality authorized
    viii. Documentation of clinical information as entered by the provider on the referral request form
    ix. Time period that the authorization is approved for
b. A hard copy of the referral request along with the medical information submitted be maintained on the file within the UM Department.

REFERENCES

Health and Safety Code, Section 1374.16 (A-f)
Department of Managed Health Care, Technical Assistance Guide, Aug 2012
LA Care Health Plan, Audit Tool, 2013
28 CCR 1300.74.16