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, 2/22
Department Head: Sr. Director, UM		**Date: 4/25/22**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 4/25/22**	

PURPOSE

This policy defines the process which Blue Shield of California Promise Health Plan (Blue Shield Promise) shall authorize an Out of Network (OON) Standing Referral.

POLICY

Blue Shield Promise does not require prior authorization with in-network providers for standing referrals. If a OON request is submitted, 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.

Out of Network 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.

A request for an Out of Network 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.

The Out of Network standing 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.

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

If Blue Shield Promise receives a OON request:

I. Requesting a Standing Referral:

a. When authorizing a standing referral to a specialist for the treatment of a disabling, life threatening or degenerative condition, the following shall occur:
    i. The request shall be made by the member's PCP, specialist or the member.
    ii. 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.
    iii. If no specialist qualified to treat the disabling condition is available in the network, then the referral shall be made to a non-contracted provider, as outlined in Policy & Procedure 70.2.16 Non Contracted Providers.
b. 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. 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"

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