blue california
Promise Health Plan

Policy Title: Specialty Care Referral Management		POLICY #: 70.2.7 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 11/97	**Effective Date** 5/19	**Revision Date** 12/18, 7/21
Department Head: Mirela Albertsen, UM Senior Director		**Date: 9/23/21**	
Medical Services/P&T Committee: (If Applicable)		**Date: 9/23/21**	

PURPOSE

To establish and define mechanisms for the Blue Shield of California Promise Health Plan (Blue Shield Promise) Utilization Management (UM) Department to approve, modify or deny member utilization of specialty care services.

POLICY

Primary Care Providers (PCPs) are responsible for providing all routine health care services, including preventive care, to their enrolled members. However, Blue Shield Promise recognizes that many time members may require care that must be rendered by qualified specialists. In most circumstances patient referrals to medical specialists will be submitted prospectively to the Blue Shield Promise UM department for review and authorization.

Enrollees have direct access to the following services without obtaining prior authorization:
Emergency Services
Family Planning Services
Preventive Services
Basic Prenatal Care
Sexually Transmitted Disease Services
HIV Testing
Women's health specialists for routine and preventive health care services, including breast exams, mammograms, and Pap tests.

PROCEDURE

PRIMARY CARE PROVIDER:
When, in the opinion of the PCP, a member referral to a specialist is indicated, the designated staff member at the PCP's office will forward an authorization request to the Plan. The PCP's office shall maintain a log indicating the patient information, date of request, type of specialist, clinical reason for referral, and Blue Shield Promise authorization number. Details of the tracking of completion of the referral process are detailed later in this section.

REQUEST FOR CONSULTATION:
The PCP's office will fully complete the Request for Consultation form. The request is logged by the PCP's office as described above. Routine requests may be faxed. Urgent requests may be

faxed or telephoned in. If telephoned they are to be followed by a fax. Written or electronic confirmation of the authorization determination will be sent to the provider/member within 24 hours of the verbal endorsement.

FOLLOW UP:
If the request for consultation/referral satisfies Blue Shield Promise UM criteria both the PCP and the specialty provider will be notified electronically by the Blue Shield Promise Health Plan UM department within 24 hours of the decision. Blue Shield Promise requires participating providers to make an appointment for its Members available and scheduled within 15 days of the request. Adherence to this requirement is monitored and addressed monthly with participating providers.

After review of the consultation results and recommendations, the PCP may request additional treatment authorization from Blue Shield Promise UM if clinically indicated. Contracted specialists may also request additional treatment/care directly from the UM department.

BLUE SHIELD PROMISE UTILIZATION MANGEMENT:
Upon receipt of request for specialty referral/consultation, UM staff will enter the request in the Auth Accel The Case Manager will review the medical information on the request form. The information will then be assessed according to Milliman Care Guidelines or PCP Scope of Care. Evaluation of requests and notification of approval or requests for additional information will be processed as outlined in P&P 70.2.50. Requests that are pended, modified, or denied will also be processed as described in P&P 10.2.11 Medi-Cal or 50.2.11 Medicare.

CRITERIA SATISFIED:
If criteria i.e. (Milliman Care Guidelines, PCP Scope of Care) for referral/consultation are clearly satisfied by the information provided, the Case Manager or designee will complete the referral in Auth Accel and record the authorization number. The UM department will then notify the PCP of the approval as outlined above.

CRITERIA NOT SATISFIED:
If the information provided on the request is not sufficient criteria the Case Manager or designee may contact the PCP/specialist for additional information. If the additional information does not satisfy criteria, the request will be forwarded to the Blue Shield Promise Senior Medical Director or physician reviewer for evaluation.

MEDICAL REVIEW:
The Senior Medical Director or physician reviewer may approve the request or may contact the requesting PCP for additional information.

If the Senior Medical Director or physician reviewer requires a specialist consultation the Request for Consultation and other medical information obtained will be forwarded to the Blue Shield Promise Specialty Panel Physician who is Board eligible for evaluation.

If after Specialty Advisor Review the criteria are not satisfied the Senior Medical Director or physician reviewer will indicate denial on the Request for Consultation form.

A denial notification and a copy of the specific utilization review criteria/guidelines or benefit provision used as a basis for the denial will be sent to the member and the provider.

The PCP/provider may telephonically confer with the Senior Medical Director to discuss the denial decision and/or to ask for reconsideration.

For further denial information please see policy and procedure 10.2.11 – Medi-Cal or 50.2.11 Medicare.

REFERENCES