blue california
Promise Health Plan

Policy Title: Specialty Care Referral Management		POLICY #: 10.02.53 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 11/97	**Effective Date** 5/19	**Revision Date** 12/18, 7/21, 9/22, 3/24
VP Approval: Tracy Alvarez, VP, Medical Care Solutions		**Date of Approval:** **3/12/2024**	
Medical Services/P&T Committee: (If Applicable) Jennifer Nuovo, MD, Blue Shield Promise Chief Medical Officer		**Date of Committee Review:** **3/12/2024**	

A. 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 out-of-network specialty care services.

B. DEFINITIONS

N/A

C. POLICY

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

II. Blue Shield Promise does not require prior authorization with in-network providers for specialty referrals. When an OON request is submitted, Blue Shield Promise will provide a referral to a specialist if the PCP, in consultation with the specialist, if any, and Blue Shield Promise's Medical Director or designee, determines that a member needs continuing care for his/her chronic, disabling condition in accordance with Health & Safety Code §1374.16(a).

III. Members have direct access to the following services without obtaining prior authorization:

a. Basic prenatal care
b. Emergency services
c. Family planning services
d. HIV testing and counseling
e. Initial assessment for mental health and substance use disorders (SUD)
f. Preventive services
g. Sexually transmitted disease services
h. Women's health specialists for routine and preventive healthcare services, including breast exams, mammograms, and Pap tests

D. PROCEDURE

I. When, in the opinion of the PCP, a referral to an OON specialist is indicated, the designated staff member at the PCP's office will forward an authorization request to the plan. The PCP's office will 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.

II. 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.

III. Upon receipt of request for an OON specialty referral/consultation, UM staff will enter the request in Auth Accel. The UM clinician will review the medical information on the request form. The information will then be assessed according to Medi-Cal guidelines or MCG guidelines, as applicable. Evaluation of requests and notification of approval or requests for additional information will be processed as outlined in UM P&P 10.02.38 Prior Authorization Review. Requests that are pended, modified, or denied will also be processed as described in UM P&P 10.02.08 Authorization Denial, Pending/Deferral, and/or Modification Notification. Blue Shield Promise will follow authorization procedures that meet the minimum requirements in accordance with Health and Safety Code (HSC) section 1367.01.

IV. If the request for consultation/referral satisfies Blue Shield Promise UM criteria, the clinician or designee will complete the referral in Auth Accel and record the authorization number. Both the PCP and the OON specialty provider will be notified electronically by the Blue Shield Promise UM department within 24 hours of the decision.

V. If the information provided on the request is not sufficient or does not meet criteria, the clinician 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.

VI. The Senior Medical Director or physician reviewer may approve the request or

may contact the requesting PCP for additional information.

VII. 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.

VIII. 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.

IX. 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.

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

E. MONITORING

Blue Shield Promise conducts focused audits on specialty referrals at least once every twelve (12) months to ensure meaningful and timely exchange of medical information pertinent to the treatment plan of the member. Blue Shield Promise shall ensure the provision of medically necessary services is appropriate and decisions are based on nationally recognized criteria or guidelines.

I. The tracking system shall include authorized, denied, deferred, or modified referrals.
   a. Authorized – tracking shall include timeframe for the turn-around-time (TAT) of the referral, report sent by the consulting physician, documentation or follow-up of the referral made to a specialist, and follow-up for missed appointment.
   b. Denied tracking shall include TAT, documentation of notice of the denial to the provider, evidence of notice to the member, and the denial reason based on nationally recognized criteria, plus the offer of alternative treatment and follow- up.
   c. Modified tracking shall include TAT, documentation of notice of the modification to the provider, evidence of notice to the member, and the modification reason.
   d. Deferral-tracking shall include TAT, outcome of each deferral file, notice of the decision to the member and provider.
   e. Frequency of monitoring may increase to 2 times per year or up to a quarterly basis if a trend of non-compliance is identified.
   f. A Specialty tracking report will be run monthly and shall be presented to the appropriate committee on a quarterly basis.

F. REPORTING

N/A

G. REFERENCES & ATTACHMENTS

1. HSC sections 1367.01 & 1374.16(a)
2. 10.02.08 Authorization Denial, Pending/Deferral, and/or Modification Notification
3. 10.02.38 Prior Authorization Review
4. DHCS Contract Exhibit A, Attachment III, Section 2.3
5. Medi-Cal Provider Manual Section 7.5.3

H. REVISION HISTORY

Date	Modification (Reviewed and/or Revised)	E-Filing Number
3/2024	2024 Annual Review • Updated regulatory requirements per DHCS • Added references • Formatting and grammatical updates • Clarified OON language	
02/2023	Updated Regulatory Requirements DHCS	