Government Business Division
Policies and Procedures

Section (Primary Department) **Utilization Management**		**SUBJECT (Document Title)** **Access to Specialty Care - CA**	
Effective Date 09/15/2000	**Date of Last Review** 04/18/2024	**Date of Last Revision** 04/18/2024	**Dept. Approval Date** 04/18/2024
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Members requiring care outside the expertise of the Primary Care Provider (PCP) shall be referred to an appropriate specialist within the Anthem Medicaid (Anthem) network, including women's health.

Anthem allows women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife, Certified Nurse Practitioners) within the network for women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health specialist.

Anthem makes nurse practitioner services available to its members. Members are allowed to use the services of out-of-network nurse practitioners if a nurse practitioner is not available in the member's service area within Anthem's network.

The "*Access to Care Unit"* is available to provide assistance to the PCP in locating a specialist in the following instances:

- When an in-network specialist is not available.
- Timely access to an in-network specialist is not available.
- For seldom used or unusual specialty services outside the network when an in-network specialist is unavailable and when the service is determined medically necessary.
- When a provider considers services morally unacceptable, a request for a referral to an out-of-network provider may be authorized based on medical necessity and availability of in-network specialists.

DEFINITIONS:

None

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PROCEDURE:

A. The PCP will refer members requiring specialty care to an appropriate in-network Specialist, no authorization is required by Anthem to see an in network Specialist. If the PCP is unable to locate an in-network Specialist within the geographic area, they will contact the Customer Care Center (CCC) or Medical Management (includes both Utilization Management (UM) and Case Management (CM)) Department for assistance.

B. If the Customer Care Center or Medical Management staff is unable to locate an appropriate Specialist in the desired geographic area that has timely access, a referral will be made to the *"Access to Care Unit."* The *"Access to Care Unit"* staff, in collaboration with the Provider Engagement and Contracting Department, use additional resources to locate an appropriate Specialist.

   a. If the *"Access to Care Unit"* staff is unable to find an in-network Specialist within the geographic area, a referral will be made to an out-of-network Specialist. Standard plan rates will be offered. If the accepting Specialist refuses the plan rates of reimbursement, the *"Access to Care Unit"* staff will negotiate a mutually agreed upon rate of reimbursement.
   b. In the event of a provider shortage, Anthem's *"Access to Care Unit"* staff may assist in arranging for a member to receive timely care as necessary for their health condition if timely appointments within the contractually required time and distance standards are not available. This may include locating available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the Member's needs. (see CA Medicaid Policy #CA_PNXX_033 "Access to Care Standards")

C. The determination shall be made within seventy-two (72) hours for urgent requests and three (3) business days for non-urgent requests 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.

D. The *"Access to Care Unit"* staff will notify the PCP of the Specialist's name/address/phone number and the authorization number. The PCP will notify the member of the scheduled appointment.

E. The referral process does not entail any additional expense to Department of Health Care Services.

F. Out-of-network specialty referrals are tracked in the electronic Anthem Care Management Platform (ACMP) system. An Authorization and a Claims data report is published on a quarterly basis which may be reconciled to determine whether or not the member utilized the authorization.

REFERENCES:

- CA Anthem Medicaid Policy # CA_PNXX_033 "Access to Care Standards"
- DHCS and LA Care Contracts, Exhibit A, Attachment III; 5.2.1
- Medi-Cal EOC 2024
- Provider Operations Manual, 2024

RESPONSIBLE DEPARTMENTS:

Primary Department: Utilization Management

Secondary Department(s): None

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
04/18/24	• Annual Review • References section updated to 2024 EOC and Provider Operations Manual
07/27/23	• Off Cycle Review • Added Nurse Practitioner, per DHCS request, under Policy section • Updated References section
05/31/23	• Annual Review • Updated Procedure section • Updated References section • Replaced "N/A" with "None" under Secondary Department(s) sub-header
05/26/22	• Annual Review • Updated References
05/27/21	• Annual Review, no changes
05/27/20	• Annual Review

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Review Date	Changes
	• Updated References
10/30/19	• Off Cycle Review • Added "timely access" to reason for ATC referral per suggestion from DHCS • Updated References
05/29/19	• Annual Review • Updated References • Changed WMDS to ACMP
05/14/18	• Annual review, updated references
05/02/17	• Changed 5 business days to 3 business days for OON reviews.
05/30/16	• Annual review. Update References.
06/30/15	• Removed all other LOB other than Medi-Cal • Updated references
09/04/14	• Removed Healthy Families • Added the 72H for urgent and 5 business days for non-urgent requests under procedure part C. • Changed header to Government Business Division
09/24/13	• Added verbiage back in concerning tracking and monitoring, OON referrals in WMDS as it was determined that reports are generated on a quarterly basis.
06/18/13	• Added contractual requirement regarding access to care in the event of a provider shortage. • Expanded abbreviation of PE&C • Removed statement about transportation in B.a. as it is irrelevant to this particular policy. • Deleted last bullet point about WMDS tracking as this is not currently being performed. • Updated references
08/24/12	• Corrected formatting and grammar errors • Changed reference from Anthem Blue Cross State Sponsored Business to Anthem Medicaid • Changed reference from Care Management to Medical Management • Updated references • Added revision history to policy
09/15/00	• Policy created